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MINORITY COMMUNITY HEALTH COALITION
DEMONSTRATION GRANT PROGRAM (1986-1989)
MULTIPLE CASE STUDY

VOLUME II
FINAL
REPORT

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It is the wish of everyone involved that this study will serve the purpose for which it was intended--to gain knowledge and insight into how racial/ethnic minority health coalitions can effectively promote health-risk reduction in their respective communities.

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EXECUTIVE SUMMARY

Background

Under its Minority Community Health Coalition Demonstration Grant Program, the U.S. Department of Health and Human Services' (DHHS) Office of Minority Health (OMH) awarded 26 two-year grants between 1986 and 1989 "for projects which demonstrate methods of developing community health coalitions which can effectively promote risk factor reduction among minority populations." OMH funding for the 1989 cohort of projects concluded in 1991. As part of the responsibility of the granting agency, OMH commissioned a study of the 26 projects funded between 1986 and 1989. This study represents OMH's efforts to continue to improve interventions that address health risk factors among racial/ethnic minority populations and to increase the effectiveness of its community coalition grant program. Minority populations are defined as: (1) African Americans; (2) Hispanics; (3) Asian/Pacific Islanders; and (4) Native American/Alaskan Natives. The OMH Minority Community Health Coalition Demonstration Grant Program (1986-1989) Multiple Case Study was carried out by Tonya, Inc. between May 1992 and October 1993 under contract with the DHHS.

Objectives

This study was conducted for the purpose of determining how coalitions can effectively promote health risk reduction at the community level among minority populations, defined as African American, Asian/Pacific Islanders, Hispanics, and Native Americans/Alaska Natives. The study had five objectives: (1) to evaluate the process of coalition and intervention development from project initiation through implementation and completion, (2) to evaluate project outcomes relative to predefined project goals and objectives (3) to identify elements of coalition and project successes and failures that may be used as working hypotheses for future research studies, (4) to measure key aspects of the OMH Minority Community Health Coalition Demonstration Grant Program's administration and operations, and (5) to provide recommendations on ways in which projects can enhance their health promotion efforts and on steps that OMH can take to maximize the effectiveness of its community health coalition grant program.

Approach

This retrospective study employed a multiple-case-study approach that called for a qualitative research design. The Tonya, Inc. Study Team visited 13 (50 percent) of the 26 project sites to interview project staff, coalition members, volunteers, and others who participated in project activities. Upon completion of the 13 site visits, 13 case studies were compiled (see Section III), 35 hypotheses were generated, aggregate multi-case data were analyzed (see Section IV), and conclusions and recommendations were formulated for consideration by the projects' and by OMH (see Section V).

In order to provide OMH with information on the factors that seem to enable projects to achieve positive outcomes, the study did not make comparisons between projects, but rather sought to determine which characteristics are associated with which positive outcomes across projects.

Review of secondary (documentary) data on the 26 projects yielded information on such factors as type of grantee organization, ethnicity of target population, health problems addressed, evaluation efforts, and continuation of coalitions and intervention programs (See Section IV). Careful analysis of primary data gathered through the site visits lent insights into more subtle and intangible elements, such as a project's contribution to a community's sense of empowerment and the spread effects of a project beyond its original target population and health-problem focus.

Soon after completing the first few site visits, the Study Team began to assess the nature of the positive project outcomes that it was finding and attempted to identify which project characteristics, in combination, seemed most likely to be associated with these positive outcomes. The five positive outcomes (dependent variables) identified were (1) achievement of project objectives, (2) coalition continuation, (3) intervention program continuation, (4) community empowerment, and (5) spread effects. The 35 project characteristics (independent variables) identified included factors related to the overall project (e.g., target population selection, target health problem identification, evaluation), the project coalition (e.g., community leader involvement, organizational composition, roles and functions), program staff (e.g., roles and functions, ethnicity, community volunteer participation), and intervention program design and implementation (e.g., target community participation, cultural appropriateness, flexibility). Thirty-five hypotheses were generated to test the associations between positive project outcomes and specific characteristics. The complete list of hypotheses can be found in Section IV of this report.

Major Findings

Review of secondary data on all 26 projects showed the following:

1. The OMH grants significantly stimulated the growth of the kinds of coalitions intended. Seventy-three percent of the project coalitions did not exist prior to OMH funding.

2. The coalitions funded by OMH appear to be long lasting. An overwhelming majority (81 percent) continued after the end of OMH funding, and 18 (69 percent) of them were still operational in 1993 in the same or modified form.

3. After the end of their OMH grants, the continuing intervention programs obtained funding from other public and private sources in amounts that ranged from $50,000 to $2.3 million.

Analysis of primary data on 13 projects revealed strong associations between the following positive outcomes and project characteristics:

1. **Achievement of Project Objectives:** early attention to project evaluation, including the collection of baseline data and the conduct of formative research; active involvement of community leaders in coalition decisionmaking activities; target-community participation in intervention program design and implementation; active involvement of community volunteers in program design and implementation; flexibility in program design and implementation; and OMH assistance.

2. **Continuation of Coalition:** active involvement of community leaders in coalition decisionmaking and activities, program staff composition reflecting the ethnicity of the target community, and cultural appropriateness of program design and implementation.

3. **Continuation of Intervention Program:** active involvement of community volunteers in program design and implementation, and cultural appropriateness of program design and implementation.

4. **Community Empowerment:** community-based organization (CBO) serving as grantee and coalition lead organization, active involvement of community leaders in coalition decisionmaking and activities, program staff composition reflecting the ethnicity of the target community, active involvement of community volunteers in program design and implementation, and cultural appropriateness of program design and implementation.

5. **Spread Effects:** active involvement of community leaders in coalition decisionmaking and activities, target-community participation in program design and implementation, active involvement of community volunteers in program design and implementation, and cultural appropriateness in program design and implementation.

Study Conclusions and Recommendations

Conclusions for Projects

A major conclusion of this study is that there appears to be an emergence of a set of characteristics that in combination are likely to enable projects to attain the five desirable outcomes described above. These project characteristics are as follows:

1. Delineation of project goals and objectives that are clear, feasible, and achievable.

2. Designation of a CBO that meets all criteria for funding as the grantee and coalition lead entity.

3. Ensuring CBO membership in the coalition and active participation in intervention program activities.

4. Active involvement of recognized, respected community leaders in coalition decisionmaking and program activities.

5. Ensuring that a majority of coalition members and project staff have first-hand familiarity with the culture and language of the target community and reflect the ethnicity of the target population.

6. Early attention to the evaluation component, including the collection of baseline data and the conduct of formative research.

7. Engagement of the target community in all aspects of the program, including needs assessment, design, implementation, and ongoing monitoring of activities.

8. Shaping the program's design and implementation to the target community and population to ensure maximum cultural appropriateness and flexibility in all aspects of the program, (e.g., selection of intervention sites, outreach strategies, and development of educational and training materials).

9. Active involvement of community volunteers and/or community consultants

in program design, implementation, and evaluation.

10. Receipt of technical assistance as needed during each critical phase of application preparation, program design, implementation, and evaluation.

Conclusions for OMH

1. An analysis of the 26 grant applications funded between 1986 and 1989 revealed a wide variation in the feasibility and measurability of the project objectives and the sophistication and appropriateness of evaluation plans. Further analysis showed that applications often contained incomplete demographic information and presented unclear rationales for the selection of the risk factors to be addressed and intervention strategies to be employed.

2. Five (38 percent) of the project grantees visited on site expressed the feeling that OMH had been helpful and responsive during the funding periods. They also appreciated the freedom they had to shape their projects on the basis of local circumstances. However, they all indicated that they would have liked more time and funding to carry out their projects.

3. A majority of the site-visit project grantees indicated that they would have welcomed more OMH technical assistance during the application preparation, evaluation design, and/or early program implementation phases of their projects. They also felt that more feedback on progress reports would have been helpful.

The full report provides details of the context under which these projects were administered by OMH.

Major Recommendations for Projects

1. To the degree feasible, incorporate into the project design the above 10 project characteristics associated with positive outcomes.

2. Perform a community needs assessment at the outset of the project by collecting available demographic and epidemiological data and employing rapid assessment methods (e.g., focus groups) with the target community members to form a basis for developing the intervention program design, and repeat the assessment periodically to ensure that the program is meeting the perceived needs of the community.

3. Where there is need, design programs that effectively take into account cultural complexity, i.e., involve one or more languages requiring translation, focus on an immigrant population, or involve more than one racial/ethnic minority population or subpopulation, and make sure these factors are addressed in the design.

4. If one of a project's objectives is increased access to health care services, include representatives of the health care establishment who have authority, or the delegated authority, to actually influence, and if necessary modify, the health care system.

5. Utilize all available resources, including the OMH Resource Center, for needed technical assistance during application preparation, program design and implementation, and evaluation.

6. Communicate with other projects--OMH-funded or otherwise--to share experiences and compare approaches in addressing similar target populations and health problems.

Major Recommendations for OMH

1. Consider further expanding the project funding period from three to five years. The first two years could be devoted to planning, coalition organization, baseline data gathering and formative evaluation, and staff capacity building. Projects that achieve a high level of performance during the first two years would be eligible for an additional three years of OMH support.

2. Strengthen the application review process to ensure that the applications selected for funding are technically sound and contain the above-noted project characteristics. Ensure that grant reviewers have the requisite technical skills and sociocultural expertise necessary to review OMH Minority Community Health Coalition Demonstration Grant Program applications.

3. Strengthen evaluation guidelines by instructing project grantees to conduct baseline and formative evaluation. Most projects need technical assistance in this crucial area. It could come from OMH (central or regional offices) or from a contractor; in any case, OMH should have in-house capability to evaluate the design of baseline and formative research.

4. Develop additional mechanisms to provide timely and appropriate technical assistance at critical points in the life of projects: grant application and project design (and possibly re-design), budget development, baseline and formative research, documentation for project monitoring, and evaluation.

5. Strengthen the OMH Resource Center services by a) establishing a film and video library on health topics/issues relevant to ethnic/racial minority communities; b) allowing applicants and grantees to tap the Resource Center's information database directly through computer link-up; c) publishing a grantee newsletter to facilitate networking and the sharing of information; and d) ensuring the participation of a Resource Center representative in all annual grantee meetings to provide updates on available information and services.

6. Improve coordination and information sharing within DHHS and with other Federal agencies that provide assistance and support to racial/ethnic minority communities.

7. Conduct research to test the hypotheses generated by this study with a number of racial/ethnic minority health projects.

Recommendations for Future Research

Many findings from this research are consistent with conventional wisdom regarding community involvement, participation, and empowerment through coalition development. It is important, however, that future research continue to advance our knowledge beyond conventional wisdom so that health policies and programs can effectively serve diverse racial/ethnic minority communities. Following are the major recommendations for future research.

1. Determine what coalition models are most effective in terms of achieving the five outcome variables listed in this report. Give attention to coalition members' prior relationships, statuses, roles within the community, differing agendas, and reasons for joining the coalition (both explicit and implicit). Determine the relationship of the size, composition, and functions of coalitions to the interactional dynamics and outcomes of coalition effects. Special focus should be placed on sociocultural differences and similarities that may influence the ways various minority communities shape and sustain coalitions.

2. Determine whether, how, and to what degree effective intervention program designs are relevant within a specific sociocultural context. The objective

would be to develop an ethnic-specific design for implementing effective intervention programs that could, with modifications, have crosscultural applicability.

3. Determine the extent to which projects can attract and retain community volunteers and the degree to which the roles and activities of those volunteers enable projects to achieve coalition continuation, intervention program continuation, community empowerment, and spread effects.

I. INTRODUCTION

Under its Minority Community Health Coalition Demonstration Grant Program, the U.S. Department of Health and Human Services' (DHHS) Office of Minority Health (OMH) awarded 26 two-year grants between 1986 and 1989 "for projects which demonstrate methods of developing community health coalitions which can effectively promote risk factor reduction among minority populations." These 26 projects were carried out in a variety of urban and rural settings throughout the country and targeted a range of minority populations and health problems. The populations included African Americans, Asians/Pacific Islanders, Hispanics, and Native Americans/Alaska Natives. The projects addressed six health problems identified in the 1985 DHHS *Secretary's Report on Black and Minority Health*: (1) cancer; (2) cardiovascular disease and stroke; (3) chemical dependency; (4) diabetes; (5) homicide, suicide, and accidents; and (6) infant mortality; in addition, HIV/AIDS added to the list in 1988.

OMH grant funding for the 1989 cohort of projects concluded in 1991, and at that point OMH decided to conduct an evaluation of the 26 projects funded between 1986 and 1989 in order to obtain information required to increase the effectiveness of its community coalition grant program. Moreover, OMH's authorizing legislation, the Disadvantaged Minority Health Improvement Act of 1990, directed the Secretary of DHHS to provide for "evaluations of projects carried out with financial assistance" under authority of the legislation and for "dissemination of information developed as a result of such projects." Under contract to OMH, the OMH Minority Community Health Coalition Demonstration Grant (1986-1989) Program Multiple Case Study was carried out by the firm of Tonya, Inc. between May 1992 and October 1993.

OMH will use the results of this study to enhance its capability to make well-informed program planning decisions. This is especially important in selecting for funding those types of coalition intervention demonstrations that are most likely to succeed in promoting health risk reduction and that may thus possess wider potential applicability for improving the health status of racial/ethnic minority populations throughout the United States.

II. STUDY DESIGN AND PROCEDURES

A. Purpose

This study was conducted to determine how coalitions can effectively promote minority health-risk reduction at the community level. The study had five objectives:

1. To evaluate the process of coalition and intervention development from project initiation through implementation and completion.

2. To evaluate project outcomes relative to predefined project goals and objectives.

3. To identify elements of coalition and project successes and failures that may be used as working hypotheses for future research studies.

4. To measure key aspects of the OMH Minority Community Health Coalition Demonstration Grant Program's administration and operations.

5. To provide recommendations on steps that projects can undertake to enhance health promotion efforts and on ways in which OMH can conduct a more effective program.

It is important to give an overview of the context of this study. The projects under review tried to affect populations that are difficult to reach and that have the poorest health indicators in the United States. They attempted to do this within two-year grant periods with funding at a level of only $200,000. Where national health campaigns and other more specialized, targeted, and well-financed interventions have failed, these projects sought to make inroads on intractable health problems among the most medically underserved populations and with limited time and money. In short, the projects attempted to do more with less, in fact, much more with much less.

Because these projects represented innovative demonstration efforts shaped to the cultures and health problems of specific racial/ethnic minority communities, there is no single standard of relative success against which all of the projects can be measured. This made it more appropriate to focus on the outcomes achieved by individual projects in terms of the objectives they set for themselves, as well as on the degree to which project coalitions and interventions continued after the end of OMH funding. Therefore, the Study Team did not make comparisons between projects, but rather sought to determine which characteristics are associated with which positive outcomes across projects. In this context there were no failures--only degrees of accomplishment of stated objectives.

B. Design

This retrospective study employed a multiple-case-study approach that called for a qualitative research design rather than for quantitative, statistical survey research methods. The latter would have been infeasible because of the retrospective nature of the study, the small number of projects to be studied, and the extensive time and relatively high cost entailed. A qualitative research approach better captures individual project profiles and processes involved in community coalition demonstration efforts. The multiple-case-study approach permits examination of each project's unique features, processes, and outcomes, while allowing for the inductive emergence of general principles and patterns for the development and testing of hypotheses. The study design entailed two phases of data collection: the review of secondary documentary project information and the gathering of primary data through project site visits.

Since it would not have been possible to make site visits to all of the projects, it was determined that visits would be made to 13 (50 percent) of them. The 13 sites were selected so as to ensure representativeness with regard to four factors: year of funding (since grantee applicants received somewhat different instructions from OMH) depending on the year of award), race/ethnicity, location (including demographic setting and geographic region), and health problem and associated risks addressed.

Two interview instruments were developed to gather primary data: Instrument I for project coalition members and program staff and Instrument II for project beneficiaries. These instruments were not questionnaires (to be filled out by respondents), but rather interview schedules (to guide discussion during an interview). Both instruments were tested in several ways. First, three outside reviewers experienced in minority health issues and intervention programs reviewed the instruments and made cogent recommendations. Next, three projects were selected for administering Interview Instrument I and Interview Instrument II at three sites, to a total of nine staff persons and targeted beneficiaries. The six who were project staff/coalition members also provided their insights and suggested modifications for improving the Interview Instrument II. Finally, through correspondence and in meetings held in July 1992, the study's expert Technical Advisory Committee (TAC) and many of the former project grantees made useful suggestions regarding the study design in general and the interview instruments in particular. Based on this advice, both interview instruments were edited to eliminate redundancies, enhance clarity, improve "flow," and reduce length and respondent time burden.

The study's design and interview instruments were then submitted for approval to the U.S. Office of Management and Budget (OMB). OMB's conditions for approval of the study were as follows: (1) due to the retrospective approach to the study and the self-reported nature of much of the data, project beneficiaries would not be interviewed, and the study results would represent information only from the site-visited projects and not be generalizable to the remainder of the 26 demonstration projects; (2) the study would not

be intended to evaluate the effectiveness of the demonstration projects nor the effectiveness of certain types of coalitions; (3) the purpose of the study would be to gain more in-depth descriptive data on the process of coalition and intervention development; and (4) the information gained through these case studies would provide the basis for creating hypotheses and the further testing of such hypotheses through a more rigorous research design. As a result of these OMB conditions, the major changes in the study design were as follows:

1. This project hereafter is referred to as a "study" rather than an "evaluation."

2. Beneficiaries were not interviewed during site visits and the instrument developed for this purpose is not included in this report.

3. Emphasis was placed on the development of hypotheses for future research rather than on determination of coalition and project effectiveness.

C. Procedures

The Tonya, Inc. Study Team compiled and reviewed existing secondary documentary data on the 26 projects. On this basis, profiles of each project were developed and then sent to the respective grantees to verify the contents and obtain comments and suggestions. Synopses of the 26 finalized project profiles are located in Appendix A.

The Study Team scheduled site visits making arrangements to 13 projects well in advance in order to verify, clarify, and update existing secondary information, especially in regard to learning what happened and for what reasons, to each of these projects following the conclusion of OMH grant funding. All site visits were planned to be no more disruptive of routine activities and no more burdensome on coalition members and program staff than necessary. Each site visit was composed of two Study Team members: the study director and another professional staff member selected according to his or her expertise regarding the specific minority population concerned and the health problem addressed by the project. At 11 of the 13 sites, a field research assistant indigenous to and knowledgeable about the local minority community was recruited to assist the study team in sociocultural and linguistic interpretation. The list of site-visit team members, the job description for field research assistants, and the site-visit itinerary are located in Appendix C.

The average site visit lasted two and one-half days. Each visit included direct observation (where applicable) of coalition and intervention processes, as well as individual and group interviews with coalition members, program staff, community volunteers where available, and other relevant project participants. A generic itinerary is shown below. Adjustments were made to accommodate the specifics and wishes of each site-visited project.

Day 1

- Meet with program staff for briefing on the study's purpose and objectives, review of the current status of the project and of the draft project profile, and minor adjustments to site-visit schedule;
- See program facilities and tour target community; and
- Brief the field research assistant.

Day 2

- Conduct interviews with coalition members, program staff, community volunteers, and other parties involved in the project;
- Observe ongoing service delivery or other intervention efforts; and
- Observe routine operations such as a coalition meeting or staff meeting.

Day 3

- Study Team's oral presentation of preliminary site-visit impressions to program staff,
- Open discussion, and
- Afternoon departure.

The Study Team made every effort not to disturb routine operations. The field research assistants were given honoraria in appreciation of their aid, and transportation reimbursement was provided for community volunteers who participated in interviews at eight sites. All of the Study Team visits were well received, and the study director sent letter of thanks to project hosts, together with site-visit reports and requests for clarification.

Upon completion of the site visits, the Study Team compiled case studies (see Section III), generated hypotheses and analyzed the aggregate multicase data (see Section IV), and developed preliminary conclusions and recommendations (see Section V).

D. Roles of the Technical Advisory Committee and Project Grantees

At the outset of the study, under OMH guidance, seven administrative and clinical professionals were assembled as the Technical Advisory Committee (TAC). The members were selected for their recognized expertise concerning minority populations,

and salient health-status problems, as well as for their in-depth experience in community-based health care service delivery and health-promotion/risk reduction programs. The TAC was organized to provide guidance to the study in areas of research design, information gathering, and interpretation of findings based on members' first-hand knowledge of minority populations, health risks, and programmatic approaches for addressing minority health problems.

The TAC received draft copies of all study documents, protocols and instruments for review and comments prior to their use by the Study Team. The TAC gave direct feedback through two meetings and one conference call during the course of the study.

In order to improve the design of the study, a grantee conference was convened on July 15-16, 1992, for representatives to review and critique all aspects of the proposed study, including all information collection techniques, with attention to the two interview instruments. Representatives of 19 of the 26 projects attended the conference; those unable to do so expressed their willingness to cooperate with and participate in the study in the future. A TAC meeting was held July 16-17, 1992, for the TAC members to hear the perspectives and suggestions of the grantees and to contribute their own recommendations.

Draft site-visit reports were sent to each site-visited grantee for correction of facts (if any) and comments prior to the analysis phase of the study, and copies were sent to the TAC members as well. A draft of the final report was sent to the TAC members and the grantees for feedback and comments prior to completion of the final report. A final joint meeting of the TAC members and grantees was held September 23-24, 1993, for the presentation of the study findings and recommendations by the Study Team. This meeting concluded a process of continuous communication that has sought to gain multiple insights and has attempted to keep all concerned parties abreast of the study's progress.

III. RESEARCH PROCESS AND OUTCOME

Case Studies

This section contains case studies of the 13 projects that were visited by the Study Team. Information on project coalition membership and program staff, as well as on specific intervention program elements, may be found in the project synopses, located in Appendix A.

Each of these case studies contains the following components: the context (the setting, the minority community, minority community health status), project initiation (antecedents, organization, design), project implementation, project outcomes, and project perspectives on lessons learned and suggestions for other projects and OMH.

Accidental Injury Control Minority Health Project
Lumberton, NC

In 1986, OMH made a two-year community health coalition demonstration grant award to the Robeson County Health Department to carry out the Accidental Injury Control Minority Health Project for the African American and Lumbee Indian populations of Robeson County, North Carolina.

I. The Context

The Setting

Robeson County is a large, rural county in southeastern North Carolina. It has a unique triracial population that includes the largest Native American population east of the Mississippi.

According to the 1980 census, the county's population was 101,610. The race-specific breakdown indicated that 60.5 percent of the county population was minority, compared with approximately 24 percent for the state overall. Composition by race in Robeson County was 25 percent African American, 35 percent Native American, 39.5 percent white, and 0.5 percent other.

The 1980 census also indicated that Robeson County had an overall poverty rate of 25 percent. In 24 of the county's 29 townships, more than 20 percent of the township's population falls below the poverty level. Within the remaining townships, the chronically poor (those at 75 percent of the poverty level) constitute the overwhelming majority of the working poor. Both the African American and Native American populations in the county experience a higher incidence of poverty than do white residents. African Americans consistently appear to be the most affected group; Native Americans are severely affected in certain townships.

The Communities

African Americans and Native Americans were the client populations for the project. The program targeted those minorities registered in child health clinics operated by the Robeson County Health Department. According to a report of the fiscal year 1982-83, the Robeson County Health Department had 1,795 county youth under the age of 21 registered in its child health clinics. Of that group, the highest concentration (47 percent) was in the 1-4 age group.

The Robeson County Health Department Child Health Clinic at the time provided school health screening, orthopedic clinics, infant tracking, and immunizations to Robeson

County residents under the age of 21. The clinic population consisted primarily of minority youth (89 percent) from across Robeson County.

Health Status

Generally, minorities are at greater risk of death from accidents other than motor vehicle accidents than are whites, and poor children are disproportionately affected by injuries. A study of North Carolina's Aid to Families With Dependent Children Program participants, ages 1-17 years, revealed that injuries were the leading cause of death, with a higher rate among whites for motor vehicle accidents and among minorities non-motor vehicle for accidents.

The Robeson County mortality rates for the nine leading causes of death were higher than the rates for North Carolina as a whole. Poor maternal health in the county was indicated by a high incidence of fetal death (seventh highest in North Carolina) and, indirectly, by infant deaths (eighth highest in North Carolina). These problems were compounded by a generally high fertility rate and a high rate of pregnancy among teenagers. The principal causes of disability and death from injury are those associated with motor vehicles, falls, drowning, burns, poisonings, and gunshot wounds.

The risk factors upon which this project focused were falls, accidental poisonings, motor vehicle accidents, firearms injuries, and environmental hazards. Most such deaths and injuries occur while driving, in the home, or at work.

II. Project Initiation

Antecedents

The Lumberton coalition grew out of a response to the OMH Request for Application (RFA) and a local physician's long-time interest in childhood injuries. Relying on his knowledge of grant requirements and personal contacts, he established the coalition. Thus, there was no coalition in Robeson County prior to the OMH grant.

Organization

The mission of the coalition was to reduce the number of injuries that occur to the minority children in Robeson County. The original members of the coalition included churches, community-based agencies, and individuals who were concerned about childhood injury prevention.

The composition of the initial coalition was racially diverse. Indeed, one respondent reported that the "coalition members looked good on paper." Many of the members of this early coalition had exemplary professional reputations, as well as excellent educational backgrounds. Unfortunately, few of the members of the early coalition were

from Lumberton. For example, an African American pediatrician served on the first coalition, but his practice was located in nearby South Carolina. The second form of the coalition achieved a greater degree of cohesion and group identity.

It was not until April 1987 that developing the coalition was seen as an urgent priority. Before an organizational meeting in June 1987, the project coordinator asked the original members of the coalition to indicate their interest in coalition membership. Several of them offered to continue as active members, several asked to remain involved as ex-officio advisory members, and several requested, because of other pressing commitments, to be absolved of their commitment to the coalition. An effort was then made to seek out people in the community who had both an interest in child health issues and the willingness and ability to devote both time and skill to the project.

A steering committee, consisting of representatives from each coalition organization, was formed to provide ongoing leadership for the coalition and to identify several concrete activities on which the coalition might begin work. The size of the coalition was increased to facilitate a racial/ethnic and geographic balance.

Design

The project director administered the project through the project coordinator. The project coordinator planned, scheduled, and conducted workshops and training for the Safety Ladies and for the church-based Safety Lady campaigns. The coordinator also met with the steering committee quarterly to assess and evaluate the progress of the project.

The specific intervention objectives were:

- To complete an American Academy of Pediatrics Injury Prevention Program (TIPP) survey for 100 percent of the child health clinic population,
- To ensure that 100 percent of the child health patrons who wanted a home safety assessment received one,
- To provide a one-ounce bottle of Ipecac to 100 percent of households represented in child health clinics,
- To make passive safety devices (infant and toddler carseats and smoke detectors) and injury-prevention counseling available and accessible to the African American and Native American populations of Robeson County, and
- To reduce the number of hospital admissions due to poisoning and burn injuries from scalding water by 50 percent.

The Safety Lady component of the project trained mothers from the target community as volunteers to implement the project activities in the child health clinics, followup home visits, and church-based programs.

The major project interventions included injury prevention counseling for minority parents or guardians whose children attended the Robeson County Health Department Child Health Clinic upon their completion of the TIPP Survey (the Injury Prevention Program developed by the American Academy of Pediatrics), installation or rental of passive safety devices, (e.g., smoke detectors or infant/toddler carseats), proper storage of potentially noxious substances, and public education programs on child safety and injury prevention. The project extended these services to the majority population during the second year as a result of public demand and staff recommendation.

The North Carolina Division of Health Services (DHS) and the Maternal and Child Health Care Section provided technical support to the project, such as developing a safety specialist handbook protocol and educational materials that met the specific cultural and educational needs of Robeson County's minority population. A DHS statistician assisted the project coordinator in developing data collection forms, designing the patient pre- and post-surveys, and modifying the evaluation plan as needed.

The Governor's Highway Safety Program provided technical assistance and pledged its technical support for the Safety Lady project. Other supporting agencies included the University of North Carolina Highway Safety Research Center, the Robeson County Department of Social Services, the Robeson County Sheriff's Department, and the Southeastern Family Violence Center.

III. Project Implementation

Project activities were centered at the Robeson County Health Center during the first year. Activities were expanded through churches in Robeson County townships with the largest minority populations.

The coalition's relationship with OMH was important on the community level. The coalition served to remind the big health care players in the local community of the importance of a minority health coalition. The coalition used the OMH relationship to carve out a niche for a minority organization among the white-dominated health care delivery system organizations.

As the number of new clients decreased in the Women and Infant Children's clinic and public health facilities, it became apparent to the coalition that a different approach was needed to identify clients and volunteers. The product of this effort was involvement in the public preschool program. Nonminority clients were eventually included in the project if the referral came from a public health nurse or if the child was enrolled in the county preschool program.

There was minimal cultural tailoring in the design of the project. In part, this may have been a result of the focus on installing safety devices such as smoke alarms, cabinet latches, and fire extinguishers. However, communication with the target population was greatly facilitated by the use of staff and volunteers from the target populations who first received training on how to install the devices.

The project director shared information she obtained from workshops, and coalition members received an initial orientation to the project, even though this was not part of the original plan. Training was done as the need arose, and opportunity to learn usually occurred during coalition meetings. Information was also shared with coalition members when a representative from OMH met with the group to discuss the report of the Secretary's Task Force on Black and Minority Health and how the Lumberton Project related to that report. Further, the project used telephone contact to obtain the input of coalition members who were unable to attend a scheduled meeting. This resulted in active participation and vested interest by most of the coalition members.

The project evaluation used internal project-based approaches such as 1) daily and weekly review of project activities by the Principal Investigator (PI), steering committee, and coalition members during site visits and regular meetings and (2) quarterly written and oral reports by the PI and by the Evaluation Subcommittee through an interactive review process between the subcommittee's chairperson and the PI and project staff.

Project evaluation also included the collection of baseline data. Before beginning the implementation phase of the project, 250 clinic surveys were conducted under the direction of the state statistician, who tailored the survey to specific problems common to target populations. The survey looked at behavioral, attitudinal, and environmental factors prevalent in the homes. A post survey, using the American Academy of Pediatrics TIPP Guide, was also conducted.

IV. Project Outcomes

As a result of this project, the county has an injury prevention program in place. Not only are Robeson County Health Department employees participating in injury prevention activities, but school and civic groups are also learning and working to provide a safer environment. A corps of volunteers has been trained whose focus is safety. In order to continue to facilitate their activities, the Health Department has created a position within the Department of Health Education for a community services coordinator. Finally, a coalition on minority health has been established in Robeson County.

The project was flexible enough to address additional risk factors as they were identified, (e.g., infants falling out of bed while sleeping with parents). Cooperation between the school system and Health Department made it possible to expose students to accident prevention messages.

The PI stated in the final report, "A cumulative benefit of this project has been the awareness of ourselves and others that communities with cultural differences, social unrest, and high levels of poverty can and will work together to find solutions, if given the opportunity."

Spread Effects[1]

- Members of the coalition are now members of a minority advisory board for Robeson County Health Department.

- Members of the coalition used their participation in the project to increase their visibility and credibility as they sought political office. For example one African American coalition member was elected mayor of a predominantly white town.

- Representatives from each level of participation (coalition, staff, and volunteers) reported an increase in safety knowledge and in changing their personal behavior. They now persuade family and friends to take preventive measures.

- The coalition was the only tri-ethnic forum available in the county when a prominent Native American leader was assassinated during the first year of the project. The coalition was a mechanism for the ethnic groups to express their feelings and related issues, and a way to begin the process of healing.

- The focus of the project on childhood injuries and safety enhanced racial solidarity in a largely segregated community.

- At least one coalition member indicated that his participation in the training served as the basis for changes in the county's emergency services, i.e., it added a preventive health component.

- Robeson County Health Department has incorporated the safety program into its ongoing services, and the project director was hired by Robeson County.

- The project steering committee observed that the teenage population and motor vehicle accidents were neglected in the original design. Adjustments were made to accommodate this target group and risk factor.

- Requests from Health Department clients and staff led to the extension of project services to the white population of Robeson County.

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[1] Accomplishments beyond the stated project goals and objectives.

V. Lessons Learned and Suggestions

The project's coalition and program staff members provided the following experience-based perspectives and suggestions for other projects and OMH.

Lessons Learned

- The principal volunteers for the project were recruited from the county Health Department. Even though some retired professionals were recruited, an expansion of the recruitment efforts to the community would have increased the pool of community-based volunteers.

- Instruments used in project evaluation must be constructed and administered with a great deal of cultural sensitivity. Questions about educational level, employment, income, and beliefs about medical practices may offend the person being asked, unless they are asked properly.

- The best way to affect healthrisk factors for minority populations is to assist clients to practice the new behavior being advocated. For example, the project purchased toddler carseats that were rented for a nominal fee to parents who could not afford to buy them.

Suggestions for Projects

- Expand volunteer recruitment outside the county Health Department to increase community participation and project ownership.

- Strengthen cultural appropriateness of intervention by developing accident prevention strategies specific to Native American culture.

Suggestions for OMH

- Increase the project funding period to at least three years.

- Include evaluation guidelines in the RFA.

- Keep procedural guidelines flexible in order to be truly responsive to the particular needs of individual minority communities.

- Provide technical assistance to help coalitions make the transition from OMH funding to post-funding status.

- Include skillbuilding as a component of grantee meetings.

- Invite at least two participants from each project to participate in grantee meetings.

MINORITY HYPERTENSION DETECTION AND CONTROL PROJECT CLEVELAND, OH

In 1986, OMH made a two-year community health coalition demonstration grant award to the Greater Cleveland High Blood Pressure Council to carry out the Minority Hypertension Detection and Control Project for the African American and Hispanic males ages 18 to 44, in the city of Cleveland, Ohio.

I. The Context

The Setting

The target population for this project lived in the Greater Cleveland area. Greater Cleveland includes the city of Cleveland, with a population of 307,264 whites and 266,558 racial/ethnic minorities (1980 U.S. Census figures), and Cuyahoga County, with an estimated population of 1,498,400.

The Community

Cleveland appears to be highly saturated with health care providers. The major players include Mt. Sinai Hospital and the Cleveland Clinic. Despite the high concentration of providers, few of the big-league providers have a sizeable African American clientele. During the period prior to OMH funding, their relationship to African American populations in Cleveland could have been characterized as either minimal or absent. In the Greater Cleveland area, limited health resources were available to the target population at the Free Clinic of Cleveland and the Cleveland Department of Health's city clinics. Some other medical facilities were available to provide care with sliding-scale fees.

Health Status

The grantee estimated that, in the city of Cleveland, 56 percent of the 171,000 residents who suffer from hypertension were African Americans. For Cuyahoga County, it was projected that 29 percent of the estimated 446,000 residents suffering from hypertension were African Americans.

In 1983 in Cuyahoga County, 7,725 deaths (49.7 percent of all deaths) were attributed to hypertension-related cardiovascular diseases. No similar data were provided for the city of Cleveland.

The target population for this project included African American and Hispanic males between the ages of 18 and 44 years. The final evaluation of the project indicates that 94 percent of the project participants were African American and six percent were Hispanic. The average age of participants was 32 years.

II. Project Initiation

Antecedents

The Greater Cleveland High Blood Pressure (GCHBP) coalition was formed in November 1979 and was formally incorporated in January 1981. The GCHBP was formed through the cooperative planning of 30 health care, educational, social service, and community organizations. In addition to the organizational membership, the coalition acquired an individual membership made up of concerned individuals from the local health care network.

The racial composition of the early coalition appeared to consist exclusively of African Americans and whites. The African Americans on the council, with a few exceptions, appear to have been persons who were particularly sensitized by their professional experiences as service providers. For example, a physician, during interviews, indicated that he saw the need for coordinated efforts in hypertension in his daily practice. whites on the coalition tended to be administrators in powerful institutions. For the whites on the coalition, like the African Americans, their presence indicated their institutional role as well as a personal demonstration of an interest and commitment to work in the community.

This original group became the core leadership, and they appear to have contributed to the continuity of focus on hypertension despite the varied funding sources of the coalition since 1979. Both African American and white members of the early coalition worked together and developed a substantial amount of trust. The activities of the early coalition were funded principally by the state.

Organization

The mission of the coalition was to reduce the incidence of hypertension in high-risk populations in Greater Cleveland through the development of education, research, advocacy programs, and services. Five health care agencies that played an active role in the target community were represented on a steering committee. Responding to the observation that minorities were not well represented in the coalition, the steering committee was expanded to include more minority representation from the community. The 29 Cleveland-based agencies participated in the project by conducting blood pressure screening, providing referrals, and offering group education sessions.

Design

The goal of the project was to demonstrate that a coalition of social, health, education, and welfare community organizations can, with support of political and other individual leadership, provide the resources and support necessary to improve the health of African American and Hispanic populations who were considered at risk for hypertension. Risk factors tracked for the purpose of this project included a history of hypertension, obesity,

and smoking behavior. The target populations were at-risk African American and Hispanic males, and the major interventions included blood pressure screening at community-based clinics and nontraditional sites.

The project benefited from contributions made by coalition members and corporate foundations. These included in-kind donations, financial awards, and personal time. In-kind donations came in the form of consultant services, legal services, health promotion materials, and administrative assistance.

Specifically, planned intervention objectives included the following:

- To identify nontraditional, highly trafficked sites in which to conduct blood pressure screening on the target population;

- To screen 5,000 African American and Hispanic males for high blood pressure within a two-year period;

- To refer all individuals found to have a resting blood pressure of 140/90 or greater to one of seven health care providers;

- To develop and use a computer-based client tracking and followup mechanism to determine whether clients were complying with medical recommendations; and

- To present "passive" and "aggressive" education activities at all blood pressure testing sites.

III. Project Implementation

The grantee organization was a consortium of social, health, welfare, and private and public educational institutions; private businesses; and individuals. The project had a staff of three: the program director, the program manager, and the administrative secretary. The program director worked fulltime; the remaining staff members served parttime. Several committees were established within the coalition to effect the success of the program. These committees included the steering committee, a screening/education coordinating subcommittee, an evaluation subcommittee, and a medical advisory committee.

The receipt of the OMH grant created an "arm" for the knowledge-based activities of the coalition. Some of the project's objectives from the onset were ambitious (screening 5,000 African American and Hispanic males) given the limited staff and the amount of time allocated by OMH. This indirectly created a strain on the relationship between the coalition and the project. Interviewees indicated this strain by speaking of the tail (i.e., the project) wagging the dog (i.e., the coalition). It was also reported that the coalition was nothing without the project. The project apparently assumed greater importance than

the other activities of the coalition, because of the amount of OMH funding and the Federal presence.

The intervention/service delivery consisted of outreach to the target population at more than 40 locations. These "indigenous" community sites provided free screening for high blood pressure screening and programs of information, counseling, referral, tracking and followup of high-risk participants.

A total of 5,879 clients were screened during the project period. Approximately one-fourth (1,470) were of the target population. During the blood pressure reading sessions, clients received information, attended education sessions, and were provided with referrals. The scope of services (i.e., screening) was not reduced even though the grant was reduced and staff and volunteers screened everyone, not just the target population. The role of volunteers who assisted in conducting blood pressure screening in the community, was important to the program. In 1986, for example, the program recruited and trained 12 volunteers who became actively involved in the program. In that first year, the volunteers contributed 1,020 hours of service.

Conflict was an implicit problem in the coalition. Specifically, while none of those in the coalition reported conflict, and indeed even denied its presence, there was reason to believe that muted conflict existed because of race. The cooperative efforts of African Americans and whites represented an implicit negotiated turf agreement. More specifically, there were areas in which "they left us alone and we left them alone." These areas had to do with roles, responsibilities, and degrees of autonomy of the coalition and the project. The intrarelationships (i.e., the relationships within the coalition) were kept free of conflict at the expense of the interrelationships (between the coalition and project). Conflict then was constrained and localized to the newly emerged tasks of the coalition. The project was the "Black thing." The coalition was the "white thing."

The growth of the coalition served as the context for the emergence of strain and conflict between the executive director and the project director. Both the executive director and the project director suggested that their differences came from personality differences. The "inexperienced" executive director of the coalition had been the secretary to the coalition before her appointment to a management position. The project director, on the other hand, was an "experienced" community organizer and health professional with many contacts in the community. The fact that the executive director had some oversight responsibilities for the project (development of a computer tracking system) and accountability to the project director appeared to have contributed to a strained working relationship between them. Some of the areas of tension may also have resulted from the organizational strain derived from overambitious goals and inadequate organizational structure.

Despite these tensions, the coalition was created to be a policymaking agency that would facilitate the implementation of interventions at the local level. As such, the coalition

made several "mini-grant" awards to encourage community agencies to sponsor education programs for the target population. It also negotiated the participation of service delivery agencies in conducting screening. The coalition was also available to offer services (training, informational materials, literature) to community groups and employers who wished to offer clients or employees high blood pressure screening and health related programs and services.

The Evaluation Committee of the coalition designated the Federation for Community Planning of Cleveland as the external evaluator for the minority program. The Federation conducted two evaluations. The report for the first year (covering 1986-87) became available in March 1988; the second-year report (covering 1987-88) became available in February 1990. Each evaluation had three components:

- A process evaluation based on taped interviews with coalition members and project staff;

- An outcome evaluation based on data from the coalition's database of client demographic and health factors, and an assessment of referral and followup efforts; and

- A summary of client experiences based on telephone interviews to ascertain the level of satisfaction with services and knowledge of causal factors leading to hypertension and its subsequent complications.

The evaluation report for the project indicates that there was a lack of adequate Hispanic staffing. Although efforts were made during the later stages of the program to correct this problem, the change in staffing occurred very late in the project. Staffing was adequate to meet the needs of the African American community only. Two of the three staff members of the program were African American and African Americans were well represented at the sites selected for direct interventions. There was no Hispanic representation on the coalition during the project's first year. This was rectified during the second year of the project.

IV. Project Outcomes

The project enhanced the visibility of the GCHBP coalition. It also demonstrated that the coalition, through the project, was addressing an unmet need in the racial/ethnic minority community.

The project demonstrated that hard-to-reach African American and Hispanic males can be found and screened in nontraditional locations. The project used its limited manpower and outreach activities to screen and educate a substantial number of persons. Of respondents interviewed over the telephone by project staff, many indicated a high degree of satisfaction with regard to both the location and the hours of screening (screening were

conducted at nontraditional locations such as work sites and the Ohio Bureau of Employment Services.

However, the critical factor in the effectiveness of the project appears to be the leadership and commitment of the project director and the PI. The project director used her professional and personal contacts to obtain needed resources for project implementation, her proposal-writing skills were effective in obtaining monetary and in-kind donations, and she had extremely good rapport with service agencies and the target population. The PI had excellent skill as a power broker. The coalition still exists to a large extent because of her effective leadership and the respect she commanded with health care providers in the community.

The coalition is now the High Blood Pressure Council of Greater Cleveland. The coalition is now structured as an advisory committee that has expanded in size to increase the range of community input and involvement. The former structure of standing committees has been replaced by adhoc task forces. In order to avoid duplicating the services provided by member agencies, the coalition no longer provides direct services.

The coalition's current mission is to reduce the incidence of hypertension in high-risk populations in Greater Cleveland through the development of education, research, advocacy programs, and services.

The coalition changed the level of community awareness of the problem of hypertension in minority populations. Because groups representing minorities sat on the steering committee, the coalition was able to work cooperatively with these representatives to learn of the perceived and actual needs of the community. The project's medical committee focused the attention of a core group of physicians on the problem of hypertension in the minority community and engendered considerable enthusiasm for this issue. The coalition was able to stimulate sufficient interest in its mission that several agencies bid to continue the work of the coalition.

Spread Effects

- The project stimulated the institution of two new, permanent screening sites in neighborhoods with high concentrations of young minority males.

- A community volunteer who was in school during the initial phase of the project, returned to school, received her degree, and is currently working as a dietician in the new OMH coalition project in the Cleveland metropolitan health system. Another volunteer decided to become a nurse after involvement in the project. She has completed her training and is now working for the Cleveland Department of Health in adult medicine.

- The Hypertension Council increased its representation of organizations serving other minority and African American communities.

- The Cleveland Free Clinic makes use of project-trained volunteers in its hypertension clinic.

- The new coalition has been invited to apply for a $50,000 state grant to continue its services to Greater Cleveland. This grant will replace the $30,000 grant Ohio has given the coalition annually since 1988.

- Cleveland is among the second generation of OMH grant recipients. The lead agency, Kenneth W. Clement Center/KAP Wellness Center, was an active participant in the Hypertension Detection and Control Project.

V. Lessons Learned and Suggestions

The project's coalition and program staff members provided the following experience-based perspectives and suggestions for other projects and OMH.

Lessons Learned

- Because of the two-organization structure and ill-defined roles, there was reported friction between the coalition executive director and the project director. This situation may have limited the coalition's effectiveness. The administrative structure of the project and the relationship between the project staff and the coalition must be clearly defined and accepted by all concerned. A dual structure can be disruptive and counterproductive.

- A major obstacle to the project was the lack of adequate funding to support the implementation activities. The result of the funding problem was that the project director was constantly waging an aggressive battle to raise funds for the project, especially through the preparation of grant proposals.

- The minority program demonstrated that hard-to-reach clients may be reached through innovative measures. In addition, it was learned that such innovative mechanisms require much planning to execute, as well as committed and well-trained personnel to carry them out. Lastly, the project demonstrated that it is difficult to rely on non-community-based "volunteerism"- in this case, community service requirements which were law enforcement-induced- to fill the needs of a service project.

Suggestions for Projects

- A coalition that is created in order to administer a demonstration project should obtain some evidence of membership commitment. This evidence may be in the form of signed letters of commitment from individual members and groups or through a formal division of tasks and responsibilities.

- Similar projects should attempt to persuade community organizations to accept responsibility for many of the tasks. In this project, the staff spent time on the actual screening, rather than on directing and coordinating the work of others.

- More effort should be devoted to ensuring the followup of clients. Many clients were screened, but they were not sufficiently motivated to followup on referrals and medical advice.

- There is a need for continued and persistent hypertension education. Educational experiences must be made available in a variety of situations and settings.

- Community networks should be set up to reach minorities in indigenous settings.

- Grant funding should be adequate to cover the planned interventions. In this project, the project director spent an inordinate amount of time attempting to raise enough funds to continue the interventions.

Suggestions for OMH

- The amount of the grant should be increased.

- The length of the funding period should be increased.

- Technical assistance should be provided early on in the project as should careful review of project goals and objectives and technical assistance as needed.

ACOA Indian Alcohol Prevention Project
Seattle, WA

In 1986, OMH made a two-year community health coalition demonstration grant award to the Seattle Indian Health Board in Seattle, Washington, to carry out the Adult Children of Alcoholics (ACOA) Indian Alcohol Prevention Project for 10 Native American groups in Seattle and six counties in the Puget Sound area.

I. The Context

The Setting

The project area covered the city of Seattle and the six-county service areas of the Puget Sound Service Unit (King, Kitsap, Mason, Pierce, Skokomish, and Thurston Counties). Located within the six-county service area are 10 federally recognized tribal groups: Klallam, Muckleshoot, Nisqually, Puyallup, Sauk-Suiattle, Skokomish, Squaxin Island, Suquamish, Stillaquamish, and Tulalip. According to the combined estimates of the Bureau of Indian Affairs and the Seattle Indian Health Board (SIHB) Registry, in 1985 the total number of Native Americans in the six-county region was 26,349.

The Communities

The 10 Indian tribes have tribal organizations and all but the Sauk-Suiattle and Stillaquamish live on reservations. The main indigenous institutions of the 10 tribes are the tribal councils; an important organization for the urban Indians of Seattle-King County is the United Indians of All Tribes. Other relevant institutions include SIHB (with over 50 percent of its board of directors required to represent Native American consumers in order to qualify for Federal funding) and the Puget Sound Indian Health Board, composed of health delegates from each of the 10 Puget Sound tribes. The target community for this project was adult children of alcoholic parents, and intervention emphasized family treatment for this population.

Health Status

The 1986 report from the Secretary's Task Force on Black and Minority Health found that alcohol is directly related to 5 of the 10 leading causes of death for Indians nationally. More than 80 percent of the Native American adults currently in alcohol treatment come from alcoholic homes. Most studies estimate that between 50 and 80 percent of the adult Native American population is alcoholic. Since Native American children are likely to have at least one parent, sibling, or extended family member with alcoholism problems, one can reasonably say that all Native American children are at risk of developing alcoholism and/or alcohol-related problems.

II. Project Initiation

Antecedents

The events that led to formation of this coalition began in 1985 when SIHB celebrated its 15th anniversary dedicated to "the elimination of Indian alcoholism - Making a Difference in our Lifetime." SIHB also marked this occasion with its First Annual Conference on American Indian Alcoholism, which it conducted in partnership with the other organizations that eventually came to form the ACOA Indian Alcohol Prevention Project coalition. SIHB provided the base of operations for this project.

Organization

The initial coalition consisted of 10 tribal councils, the SIHB, and 16 other community-based and state organizations. Two-thirds of the initial members of the coalition were either Indian or Indian-related institutions. The coalition's mission initially was the prevention of alcoholism through the ACOA approach; eventually, it became alcohol prevention through a combination of ACOA and a culturally based Native American spiritual healing approach.

Program staff was to include a PI, a project coordinator, an ACOA counselor, a secretary, and consultants to develop ACOA training curriculum, provide on-site consultation, and advise on project implementation.

A major project objective was to select and train 13 volunteer counselors, one each for the 10 tribes and one each for the three urban sites (SIHB, Indian Street Youth Project, and Indian Heritage High School). Criteria for selection included being recognized as sober and straight for two years and being recognized as a natural helper in the community. A total of 47 volunteer counselors were selected. The volunteer counselors then underwent two weeks of intensive training on the background of ACOA, family dysfunction, cultural depression, alcohol prevention intervention strategies, mass education/dissemination strategies, and family counseling techniques. Volunteer counselors in 10 of the 13 community sites (except Puyallup, Squaxin Island, and Stillaquamish tribes) then provided support groups for the adult children of alcoholics. Out of the 47 trainees (36 women and 11 men, with a median age of 40), seven dropped out (moved away or chose to work in other areas). All but two of the trainees in the first group were themselves adult children of alcoholic parents.

Design

The project focused on three major risk factors: (1) family dysfunction, described as a history of alcoholism, drug abuse, family management problems, parental abuses, and attitudes toward alcohol and drugs; (2) cultural depression including alienation, rebelliousness, lack of social bonding, antisocial behavior, little commitment to school,

lack of positive identification with the "Indian way," and poor self-image; and (3) alcohol misuse as a risk factor for death due to cirrhosis and unintentional injury.

The rationale for the intervention was based on research on risk factors and family dysfunction. The new body of study surrounding adult children of alcoholics offered a new and hopeful perspective on the devastation that alcoholism plays in Native American communities. Prior to this project, the ACOA approach had been well received on the Tulalip Reservation and in Alaskan Native villages. At the Second Annual Conference on American Indian Alcoholism, sponsored by SIHB and Seattle University, the response of tribal counselors to the ACOA material was overwhelmingly positive.

All native cultures hold the circle to be a sacred and meaningful symbol. This program, as a Native American alcohol prevention project, can best be understood if seen within its cultural context. Prevention and intervention is the action of helping "make the world for the people to live in." How one makes the world for the people to live in is powerfully expressed by the symbol of the circle with a cross inside it.

The project goal was to break the cycle of addiction. In planning intervention and prevention, part of the process was clarification of what to change and to replace within the dysfunctional cycle. It was here that the cultural form and power of the circle began. It was found that the scars from internalized racism had a devastating impact on trainees. There was need for "cultural healing." The heart of the healing was through cultural revitalization, which occurred as a result of breaking the cycle of abuse, silence, and self-denial.

The major project objectives were:

- To infuse the existing tribal and urban Indian service system with the needed training and theoretical framework to more precisely address alcohol-related dysfunction;

- To train one alcohol counselor from each of 10 tribes and three counselors from the Seattle urban Indian community in the field of ACOA, family dysfunction, cultural depression, and alcohol prevention;

- To provide an intensive two-week training to Native American community counselors with a background on ACOA, intervention strategies, mass education/dissemination strategies, and family counseling techniques; and

- To provide victims of alcoholic homes the means of separating the negative effects of alcohol misuse from the positive aspects of home life, which are cultural strengths, that can help mend self-esteem and the effects of cultural depression.

Throughout the two years of this project there was a continued attempt to revitalize the cultural form of the circle, also known in one form as Talking Circles. This power form is inherent in many teachings and is present crossculturally as the basis of group interaction, ceremony, and expression. Planning and developing the project began by taking all parts of the circle into consideration: the physical, mental, emotional, and spiritual.

III. Project Implementation

The project proposal indicated that intensive one-on-one services would be provided to approximately 200 children and teens and to 100 parents. The project did not directly offer intensive one-to-one counseling to community members. The focus of the program was to demonstrate that coalitions can effectively promote risk-factor reduction among the target population; however, project trainees became the coalition in April 1987. Trainees began support groups themselves and continue to provide ACOA information and dissemination in their communities.

Leadership support in the trainee's communities was identified as a problem area. Some trainees could not leave from their jobs to attend monthly meetings, and some were continually having to re-educate leaders about ACOA information and the trainees' role in beginning support groups. Trainees then requested administrators and the tribal council to attend an intensive training. In planning the second year's intensive training, administrators and leaders were specifically recruited for ACOA training. While many tribal leaders and alcohol program directors indicated they would attend, almost all backed out at the last minute, sending a subordinate or community person in their stead.

At some undefined point, the original or official coalition was replaced informally by a "natural" or functional coalition consisting of "natural helpers" who underwent project-sponsored ACOA training. Following training, the de facto coalition members met once a month to share experiences and to support one another in their own healing and growth. All work accomplished was volunteer. Coalition members had an experience together that created and supported a group bonding and development process. They worked through the program by building support and trust, using ceremony and ritual and openly talking with one another.

The ACOA project aimed to break the intergenerational cycle of family dysfunction, which is both a cause and an effect of alcoholism and which helps perpetuate it. The project adapted the principles and approach of ACOA to a cultural prototype found in geographically dispersed Native American societies, the Talking Circle. According to the project's basic training manual, From Nightmare to Vision, the Talking Circle brings together Native American people of all ages for the purpose of teaching, listening, and learning. Native American cultures have been handed down to successive generations by the spoken word; therefore, there is great respect for proper speaking and words of truth. The Talking Circles represent one very critical part of the training.

IV. Project Outcomes

The ACOA project developed largely on its own, without much professional guidance or input. Some of the original or official coalition members served as resource persons--trainers, advisors, and program reviewers-- but as a group they had little or nothing to do with the ACOA project or its successor programs. All staff and volunteers believed in the teachings of traditional people based on the Sacred Circle of Life; all worked hard, viewed themselves as "servants to the people," and saw their work as "spiritual" work that must be done. There was a genuine sense of ownership of the project by project staff and beneficiaries, which is evident five years after the end of OMH grant support.

In at least some tribes, natural helpers have organized communitywide social events for sober people. The purpose of such events has been to replace drinking activities with other activities that are still fun. In the words of one of the helpers, "Many of us didn't know we could have fun without alcohol. We wanted to show people that you can have fun." In some communities where most of the adult population, including the tribal council, were heavy drinkers, sobriety began to quickly grow as a result of the following combination of activities: establishing Talking Circles in local communities, sponsoring communitywide social events for sober people, conducting one-on-one counseling and referrals, encouraging teenagers to join programs, providing examples of personal transformation of natural helpers, and establishing a national organization called National Association of Native American Children of Alcoholics (NANACOA).

Some natural helpers have developed approaches to ACOA promotion and what they would call family/community healing. Examples of these approaches include activities such as staging puppet shows and directing role-playing exercises or dramas related to alcohol and family dysfunction. Others have contributed to community education by inviting guest speakers, including helpers from other areas, to reservations to tell their story of achieving sobriety.

At least 40 Native Americans, including the project's two staff members, underwent an intensive two-week training in 1987, and about 30 people were trained in 1988, totaling 70 natural helpers from about 40 Indian communities. Approximately 10 natural helpers from outside the Puget Sound area came to Seattle at their own expense and asked to be trained unofficially. Those who served as trainers included Native Americans with special skills, experience, or interests. Notable among them was a man who served informally as an advisor in spiritual and sobriety matters (having recovered from active alcoholism himself) and who helped project staff and other trainees, sometimes using rituals and ceremonies. He is an example of a natural leader and he continues to assist the project. These trainees went on to initiate Talking Circles and related interventions in their home communities. Some not too far away from Seattle attended monthly meetings in Seattle and served as de facto coalition members.

The goals and objectives of the originally proposed ACOA project were difficult to assess and somewhat unrealistic. However, the project as implemented had great impact far beyond that which was anticipated. The thrust of the project was to interrupt the perpetuation of alcoholism and related family dysfunction and to prevent more or new cases of alcoholism. Recovery from alcoholism occurred and continues to occur on a large scale. Clearly, a powerful force has been activated beyond anything envisioned in the grant application.

Spread Effects

- Every staffer and natural helper interviewed for the evaluation described the intensive training, along with the experience of forming groups and helping others, as something that changed their lives for the better in a very fundamental way. The ACOA training actually brought sobriety to some, but it is more accurate to say that a combination of the ACOA training and the experience of helping others in the ACOA way has led to deep, personal, positive changes and a new way of life, which for many includes careers that have been directed toward alcohol abuse prevention and treatment.

- A national organization--NANACOA--grew directly out of the ACOA project. There is also a NANACOA in Canada that uses the same name and that grew directly out of the Seattle-based NANACOA. NANACOA now attempts to do on a national scale what the ACOA Project did on a local/regional scale, namely helping local native communities choose appropriate natural helpers, training natural helpers, and helping helpers set up Talking Circles and other locally appropriate alcohol-prevention activities. There are now requests for help in establishing this ACOA approach in other minority communities outside the United States. For example, such a request has come from an aborigine group in Australia.

- Natural helpers went into the only all-Indian high school in the area, the Indian Heritage High School. The newly appointed principal had requested help in dealing with a student body that was nearly 100 percent involved in drugs and alcohol. The principal's wife was a trainee in the second group trained under the ACOA project. She began incorporating ACOA information and procedures in her counseling at the school and today, four years later, there are almost no active users of alcohol and mood-altering drugs among the student body.

- Some individual trainees have secured funds from the Center for Substance Abuse Prevention (CSAP) for individual projects in several communities.

- One of the two ACOA project staff members was asked to testify about NANACOA and its activities before the Select Committee on Indian Affairs in April 1992.

- In September 1992, the Indian Health Service (IHS) invited four trainers from NANACOA to train about 45 individuals in Albuquerque. The trainees came from the IHS regional staff as well as from members of a Pueblo Indian Council.

- The natural helpers trained by the project came from the ranks of teachers, fishermen, secretaries, and the like, in addition to some who were already in social service professions. Some who had no background in alcohol--except as victims of alcohol-related problems--are now working in jobs related to alcohol/drug abuse prevention or treatment. Others who were already in that field are now described as considerably more effective in their jobs as a result of the ACOA training experience.

- One tribal council is now 80 percent nondrinking. The council recently passed a law banning alcohol and drugs from any tribal building on the reservation.

V. Lessons Learned and Suggestions

The project's coalition and program staff members provided the following experience-based perspectives and suggestions for other projects and OMH.

Lessons Learned

- Within the Puget Sound area and throughout the nation, there are hundreds of Native American people needing, hoping for, and seeking a means to break the cycle of devastation from alcohol and cultural depression and to live their lives fully.

- The effects of alcoholism and alcohol abuse are multigenerational, and individuals in Native American communities are affected by these dysfunctions whether they choose to abuse alcohol or not.

- The effects of cultural oppression are multigenerational, and many individuals in Native American communities are affected in varying degrees by cultural depression. The related dysfunctions are just as significant as those related to multigenerational alcoholism.

- The current resources available to Indian communities through the IHS, the Bureau of Indian Affairs (BIA), or other agencies do not address the treatment and support needs for children of alcoholics. The professional staff members serving these populations have not received adequate training on ACOA issues and, in fact, are likely to be untreated ACOA's themselves.

- Prevention programs that are superimposed on a community and do not become a part of the community cannot effectively sustain behavior change in that community.

- Individual alcoholism intervention does not appear to be as effective as group intervention within tribal systems.

- Within Native American communities, there are cultural forms, power and teachings that promote health and wellness and can be revitalized to break the cycle of addiction.

- An intervention model that provides a safe, supportive, informative environment for healing from the effects of multigenerational alcoholism can have a major impact in creating a means for healthy, sober behavior that will reconnect individuals to their community and revitalize their spirit through cultural forms and knowledge.

Suggestions for Projects

- Prevention efforts must recognize the need for healing from cultural depression.

- Prevention efforts must address the multigenerational cycle of family behaviors and promote wellness among the adult population as a prevention effort for children. (This model presupposes that healthy adults will raise healthy children.)

Suggestions for OMH

- The grant amount and the funding period should be increased.

- Technical assistance should be provided in such areas as program development and evaluation.

- To address minority health concerns, resources should be shared with other government agencies.

- There is a need to take a leading role in assisting other agencies like IHS and the Public Health Service to fully consider unique values and cultural forms in minority communities in program development, design, and evaluation. Particular attention should be given to addressing cultural depression and integrating cultural revitalization in alcohol and mental health treatment efforts.

- The IHS should be assisted in identifying alcoholism in Native American communities as a community disease. Coordination with the IHS is needed to make available a national training model for Native American communities that addresses the multigenerational cycle of alcoholism as it affects adult children of

alcoholics. The model would include a continuum of care including addressing areas such as mental health, support group therapy for ACOA and COA, and treatment for other issues such as child sexual abuse, incest, child abuse, and suicide.

- NANACOA's efforts for a national training conference should be supported, and grant activities coordinated with the CSAP.

- Native Americans who can provide culturally appropriate and locally relevant technical assistance should be identified.

Community Coalition Project To Reduce Cancer In The District Of Columbia's High-Risk Minority Community Washington, DC

The Bureau of Cancer Control, Commission of Public Health, of the District of Columbia received an OMH Grant in 1987 to carry out the Community Coalition Project to Reduce Cancer in the District of Columbia's High-Risk (African American) Population.

I. The Context

The Setting

The population of the District of Columbia is predominantly African American. The 1980 Census reported that of the 627,000 residents in the District of Columbia, 70 percent were African American, 27 percent white, and three percent Hispanic and other ethnic minorities. Like many urban centers, much of the District is socioeconomically and ethnically segregated. It is politically divided into eight divisions or wards. The eight wards are further divided into numerous advisory neighborhood councils (ANC's). The District is governed by a mayor and the City Council composed of representatives from each of the wards and at-large members. The District has the highest overall cancer mortality in the Nation, including exceptionally high rates of cancers of the oral cavity, esophagus, larynx, prostate, and cervix, and multiple myeloma.

The Community

The project was carried out in the three highest risk wards of the District--Wards 7 and 8 and that part of Ward 6 east of the Anacostia River. These high-risk areas were identified on the bases of socioeconomic status, level of education, unemployment rate, poverty rates, incidence of cancer, and the availability of health services.

Health Status

Health services are generally available, although they are relatively scarcer in Wards 7 and 8. They include two private hospitals, two public health clinics, and a federally funded health center in Ward 7. Despite the availability of health services, cancer death rates remain unacceptably high especially in Wards 7 and 8, where 90 percent of the residents are African American and 20 percent of the families live below the poverty level. The District of Columbia has the Nation's highest cancer death rate at 233 deaths per 100,000 (the national average is 169 per 100,000). In 1985, 1,589 District residents died of cancer. The top six types--lung, colon, rectum, breast, esophageal, and pancreatic cancers--accounted for more than 60 percent of all deaths. All of these cancers are associated with either smoking, diet, underutilization of cancer screening, or a combination of these modifiable behaviors.

According to recent estimates, the average life expectancy of District residents is 4.7 years below the national average. There is an increasing gap in life expectancy and mortality between African Americans and whites living in the District for both males and females. On average, white District residents live 5.3 years longer than African American residents.

Dramatic increases in death rates have occurred within the District in the past decade. Between 1982 and 1987, the death rate for all District residents increased by 8.8 percent, with an even higher increase of 12.9 percent among African American residents. Many District residents die prematurely of acute and chronic diseases. Of the approximately 6,800 annual deaths from 1980 to 1986, 51.5 percent were premature (occurring before the age of 70). Four of every five of these premature deaths were due to five causes: cardiovascular disease, cancer, infant mortality, injuries, and drug-related or alcohol-related diseases. Cancer accounted for one out of every four of these premature deaths, ranking second only to cardiovascular diseases.

II. Project Initiation

Antecedents

The coalition for the Washington, DC, Cancer Project had its genesis in the DC Cancer Consortium which was formed in 1986 by an interracial ad hoc group. Ten members participated at the invitation of the Council of Churches of Greater Washington, including the American Cancer Society and administrators of Howard University Cancer Center and Georgetown University Cancer Center, to address the unusually high burden of cancer among low-income African Americans in the District of Columbia. All member organizations and agencies realized that to successfully reach the targeted African American communities, there must be appropriate role models on the medical staff or in the agency membership. Consequently, even those Consortium members with a tradition of all-white staffing or agency membership accepted the validity of minority representation.

The pre-project mission of the DC Cancer Consortium was to reduce the incidence and mortality of cancer in the District by 50 percent by the year 2000, a goal consistent with that of the National Cancer Institute (NCI). The short-term goal for the OMH grant period was the reduction of cancer incidence and mortality in Wards 7 and 8, and that part of Ward 6 east of the Anacostia River.

Organization

The DC Cancer Consortium consisted of 20 members representing a broad range of organizations. The Consortium was headed by a well-qualified person who was elected annually. The Consortium interventions were planned and carried out through its five subcommittees, all of which were chaired by volunteers and staffed by one project

coordinator. The project was headed by a white PI and administered by an African American program coordinator who had a health education background and experience in community organization and group dynamics. Midway through the OMH grant, an African research assistant was added to the staff.

The project's two major components were cancer screening of at-risk adults, and the first grade Know Your Body (KYB) Program. Five types (breast, cervix, prostate/testes, oral, and colo-rectal) of cancer screening were conducted at a local hospital and at community-based centers, including churches and a housing project recreation center. Community outreach was spearheaded by a minister and members of his congregation, including teenagers who conducted door-to-door cancer prevention education and distributed flyers announcing screening locations, dates, and times.

The KYB Program was adapted from a program developed in New York City and New York State schools in 1975. It was first piloted in the DC area by Georgetown University School of Medicine in the upper grades of selected elementary schools. The KYB coordinator for this project decided that the program should be introduced to first grade teachers, parents, and students.

Design

The goal of the project was to reduce the cancer incidence and mortality rates by 25 percent among African Americans living in the District of Columbia's highest risk areas of Wards 6, 7 and 8. The major interventions included community awareness media campaigns, free community-based five-site cancer screening, and the KYB cancer-awareness and risk-reduction program in all first-grade classes in Wards 7 and 8 schools. The project's process objectives were:

- To strengthen and sustain a coalition of members,
- To have community leaders understand and take ownership of the cancer prevention goals and objectives,
- To have community leaders adopt the personal health behaviors and public attitudes that will enable them to serve as effective role models in community promotion efforts, and
- To provide services and programs in a coordinated and unified fashion.

The project's outcome objectives were:

- To improve knowledge of and attitudes toward the risk factors for cancer and for the potential to reduce one's cancer risk,

- To reduce smoking prevalence,
- To improve dietary habits, and
- To increase utilization of appropriate cancer screening services.

III. Project Implementation

The DC Cancer Consortium had its genesis in a cooperative relationship between two university hospitals--Georgetown and Howard. The Consortium became a chartered voluntary coalition of nine local institutions and organizations in 1986 to coordinate programs to reduce cancer incidence and mortality rates in the District, particularly in high-risk and underserved sections of the city. The membership increased to 24 during the OMH funding period. Representatives from governmental agencies, all health care providers in the target area, voluntary health organizations, the media, churches, and community groups constituted the coalition.

The Consortium's interventions were planned and carried out through its five subcommittees on cancer screening, community organizing, education, legislation, and research, and data utilization. All were chaired by volunteers and staffed by one project coordinator. The relationship between members was generally good. Some coalition members received mini-grants to implement certain coalition activities (e.g., the Greater Washington Council of Churches received a $25,000 grant to organize and supervise youth involvement).

During the funding period, the loose partnership of hospitals expanded to include the Council of Churches of Greater Washington. This expansion signified a departure from the traditional health care providers who had made up the earlier coalition. As one respondent reported, "the church was invited to join the big players at the table." The invitation suggested that the community involvement through the church was a concession of the powerful organizations. Other members of the coalition included the American Cancer Society, the Commission of Public Health, public schools, the Medical Society of the District of Columbia, and DC General Hospital.

Once the "merger" was made, the relationship of the church to the other coalition members was tenuous. The executive director of the Council of Churches (a minister) chose not to participate in the work of any of the subcommittees other than the one he chaired, the community organizing subcommittee. He concentrated his efforts on his church's participation in health promotion and community outreach, including recruiting and providing transportation for women who were screened for breast cancer. It appears that the other Coalition members did not have a congruent view of the critical role of the church in outreach efforts. This lack of consensus over the relative importance of the church as a community organizing force was exacerbated by the complete autonomy of

the church in screening, tracking, and monitoring its own outreach efforts. In a sense, then, the church was granted power in its limited sphere.

A number of activities were planned to achieve the above objectives: conducting a baseline survey of knowledge, attitudes, and practices (KAP) of Ward 7 and 8 residents to determine gaps in services and required interventions; developing media campaigns to raise community awareness; conducting three free community-based screenings with five types of cancer screening at these locations, which were convenient to the target population; establishing a KYB program in all first-grade classes in Ward 7 and 8 schools; and educating and encouraging physicians to provide cancer screening services in the community.

The KYB Program was managed by the director of health, physical education, and safety of the DC Public Schools in collaboration with the grants program coordinator. Teacher training and technical support were provided by Georgetown School of Medicine's Laboratory for Children's Health Promotion. The significant innovations introduced in this program were the use of participatory training methods for teachers, the focus on first graders instead of higher grades, student peer teaching, the involvement of parents, and a monthly newsletter for parents and teachers.

A baseline KAP survey was conducted in the target area by telephone interview. This took one and a half years. However, followup interviews were not conducted because the cost of developing, conducting, and analyzing the baseline survey was much higher than anticipated. It was also felt that the intervention period was too short to justify allocating additional project funds for this purpose.

The Consortium hired a physician who was an experienced grant writer and researcher as chief of the Bureau of Cancer Control during the second year of OMH funding. His expertise in these areas gave him the power to define goals, objectives, and strategies for the cancer control interventions in a manner that was technically correct and more likely to ensure future funding. The inclusion of non-health-care providers on the coalition was viewed as nonessential. They were apparently rendered obsolete by the expanded cancer research focus of the chief of the Bureau of Cancer Control. However, at his initiation a seven-year data-based intervention research grant from the NCI was awarded to the DC Commission of Public Health in 1989 that revitalized and expanded the membership of the DC Cancer Consortium.

The cancer screening program continued after OMH funding. However, the five types of cancer screening were reduced to two (breast and cervix) and only women who are not covered by Medicare and Medicaid were eligible. The Greater Washington Council of Churches (represented by a different minister) is currently the only CBO represented on the Cancer Consortium. Thus, nontechnical and community-based organizations are underrepresented in an organization that had preventive health as its primary focus.

Major barriers during the first year of the project were (1) racial/ethnic tension among members of the coalition, (2) the lack of appreciation exhibited by health providers and researchers in preparing the community for the cancer screening through intensive community mobilization, and (3) competing agendas. Tension between service delivery and research interests among coalition members were not resolved during the project period; as a result research and provider interests played dominant roles in the present coalition at the expense of the community.

By the end of OMH funding, the Consortium had obtained its 501(c)3 status and secured a $500,000 three-year grant from the Federal government in 1991 for breast and cervical cancer screening. The Consortium has a full-time program director/manager and three other full-time or part-time paid staff. Another $100,000 was given to the Consortium by the Komen Foundation. The DC Hospital Association now provides space for the Consortium and its staff.

IV. Project Outcomes

During the project period 370 people were screened free of charge. The service was offered in community-based sites: a church, a community recreation center, a barbershop/beauty salon, and a hospital. The person in the Public Health Commission who was responsible for organizing and conducting cancer screening felt that the church played a key role in recruiting women to take advantage of the service. The participating minister was personally pleased that his efforts resulted in saving the lives of at least three members of his congregation. He felt that the youth and the community greatly benefitted from the program through valuable training, community outreach experience, and summer employment.

More than 50 youths were trained as health promoters (Youth to Combat Cancer). They constituted the main outreach component of the project. They were church-based and were paid through the DC Summer Youth Employment Program. Representatives from nine coalition agencies served as volunteers during either public awareness or cancer screening activities.

The KYB Program trained 60 teachers in 38 elementary schools in Wards 7 and 8. Each teacher introduced 25 first graders and their parents to the KYB approach to disease risk reduction. KYB had a very positive effect on teachers, students, and parents. Changes made to increase the program's relevance to the target population included participatory teacher training and student learning, targeting first and second grades instead of upper grades, student peer teaching, teacher creativity in planning lessons, parental involvement and learning through their providing food for cooking demonstrations, and a newsletter. One enthusiastic elementary school principal insisted on having all of his teachers trained to teach the program, not just first- and second-grade teachers.

The KYB Program did not appear to be well integrated into the project structure. Coalition resources were not fully utilized to sustain the program beyond OMH funding, and there appeared to be little appreciation of the KYB Program on the part of the health care providers.

However, the KYB school program manager was successful in securing funds from the American Health Foundation to continue the program at two schools with a part-time health educator. The number of schools continuing the KYB Program was reduced from 35 to 2 with a part-time health educator. The KYB Program received an award from the local chapter of the Association of Health, Physical Education, Recreation and Dance (AHPERD), a professional organization of health and physical education teachers, for its accomplishments during the project period. The PI of the KYB Evaluation Project based at Georgetown University, who evaluated the KYB Grade One Program for DC schools, has published extensively on this project.

Outreach in the current project appeared to be weak; only 1,237 women were screened, with seven positives identified in 1992. The person hired by the Consortium as program director was unfamiliar with activities undertaken during the OMH project period. Consequently, she was unaware of the outreach strategies developed during the OMH project period.

Spread Effects

- The project helped the lone participating minister to establish a reputation among District and Federal funding agencies that he and his church would "deliver the goods." The minister now uses the outreach technique developed during the OMH project with other church-sponsored programs (e.g., the youth outreach approach in the church's senior citizen program). Consequently, the church has received a grant to establish an emergency shelter program and support services programs. The church remains active in other community programs. The minister allied himself closely with the current mayor and has taken advantage of this political association for the benefit of the community.

- The Bureau of Cancer Control received an NCI seven-year $750,000 data-based intervention research grant that evolved from its efforts in the OMH grant program.

V. Lessons Learned and Suggestions

The project's coalition and program staff members provided the following experience-based perspectives and suggestions for other projects and OMH.

Lessons Learned

- Some of the original project goals were unrealistic, e.g., to reduce cancer incidence and mortality rates by 50 percent within a two-year period.

- The evaluation component should be designed and survey instruments prepared before the beginning of the project so that pre- and post-test intervention measures can be made in a timely fashion.

- The focus of the project changed with the style and interest of each project director. Initially, the project had a strong community outreach component. The project director who was appointed at the end of the second year of the project focused on research. Consequently, service delivery and education were de-emphasized.

- An effective coalition includes community people as service providers, outreach workers, and for grassroots representation.

- Neither age nor gender appeared to be barriers to communication between youth and beneficiaries of the cancer screening program. For example, it was reported that a middle-aged woman from the participating church felt compelled to participate in the screening because a youth showed concern about her health.

Suggestions for OMH

- The OMH funding period is too short and the grant amount too little. Since six to nine months is needed for start-up time, the minimum funding period should be from three to five years. Further, the grant amount should depend on the nature of the planned activities.

- OMH should offer technical assistance during the proposal-writing process.

- Agreement on objectives should be reached at the outset between OMH and the grantee.

Asian Cancer Awareness Project
Boston, MA

In 1987, OMH made a two-year community health coalition demonstration grant award to the South Cove Community Health Center in Boston, Massachusetts, to carry out the Cancer Awareness Project for middle-aged Chinese restaurant workers in Boston's Chinatown District.

I. The Context

The Setting

Boston Chinatown is located in the South End of Boston, bordered by the theater district and the downtown financial district. Most of the Boston Chinatown's workforce is employed in the 120 or more small businesses in Chinatown, which include restaurants, grocery stores, garment factories, and other businesses, primarily in the retail and service sector.

The Community

Massachusetts ranks 10th in the number of Asian/Pacific Islander Americans. Asian Americans are the fastest growing group in Massachusetts: 143,394 in 1990 compared with 93,891 in 1980. Of this number, 53,792 (38 percent) of the population are Chinese, while 15,499 (11 percent) are Vietnamese. While 21 percent of the State's population lives in Boston, giving Boston the greatest number of Asians (30,388), other cities have a larger percentage of Asians. Middlesex County has 51,826, or 36 percent of Massachusetts's Asian population. The Asian American population of Boston is 5.2 percent of the general population. Most Asians reside in the Allston/Brighton and South End sections of Boston.

Health Status

Many Asians and Pacific Islanders in the United States face severe barriers that prevent them from seeking or obtaining care. Economic barriers, compounded by language and cultural barriers, may lead to underutilization of health services. Without bilingual and multicultural services, the vast majority of Asians and many Pacific Islanders cannot get access to primary health care. In addition, the Office of Minority Health has recorded higher rates of esophageal, rectal, pancreatic and lung cancer among Chinese and Native Hawaiians than among the white population.

Patient data from the South Cove Community Health Center (SCCHC) show that most of the patients using the center are either poor first-generation Asians or poor Asian immigrants and refugees who speak little English and usually have no health insurance.

Chinatown workers are at risk for alcohol and tobacco use and have an unhealthy diet. The South Cove Center saw the OMH funding as an opportunity to reach a population that was not regularly served in health promotion and health education efforts in the Boston Chinatown community.

II. Project Initiation

Antecedents

The original PI for the Cancer Awareness Project (CAP) had long-standing relationships with Chinatown businessmen, as had the project's health educator. The PI used these connections to initiate the CAP, after he had reached an oral agreement with Chinese business owners. Described as a "loose network," these connections were based on trust established between individuals in the community. The plan was to use a phased approach to involving the local business community in health education and promotion efforts.

At the time of OMH funding, the PI had served about 15 years as the executive director of the South Cove Center. He had great knowledge about the health status of Boston's Asian community, and coalition members were attracted to participate because of this established association.

Organization

The joining of Asian business owners and the South Cove Center sent an important message to the community about South Cove's activities, because respected community members were participating in the coalition.

The businessmen in the community were motivated to participate in order to maintain their status as good employers and as community benefactors. The OMH initiative offered free health promotion services that could lead to a better quality of life for their workers and hence, greater worker satisfaction.

The program staff consisted of the PI, health educators from South Cove, and a translator, when needed. The project also employed the services of South Cove's medical and dental directors to assist in launching the health education intervention. Community volunteers were not part of South Cove's intervention initiative, probably for two reasons. First, members of the community being targeted (recent immigrants) may not have had jobs, and those who did were working long hours. In addition, most were recent immigrants who may not have had bilingual skills in English and Chinese. Their status as immigrants also made the stress of adjusting to a new environment more pressing than participating in health interventions. Second, volunteerism in the Asian community is perceived differently than in the Western model dominant in the United States. There exists a tradition of family interdependence among generations that may

make people feel that giving help for free outside the family is inappropriate. Consequently, the South Cove Center relied on health education staff to carry out the presentations.

Design

The OMH grant was the first pilot project to involve the restaurant industry in health education efforts in Boston Chinatown, and it helped pave the way for the community's involvement in other health coalition projects.

The intervention team anticipated tailoring the presentation to each site, with regard to differing space and time constraints, language requirements, and sufficient verbal and visual information. The project's design highlighted two areas of importance to the Asian community: the use of bilingual health education strategies and the efficacy of community-based interventions to change adult risk behaviors. The South Cove staff believed that successful interventions tied health education to constructive alternative behavior. Therefore, educating restaurant workers about the long-term effects of smoking may lead them to cut back. Traditionally, the Asian community viewed teachers and doctors as credible sources for information and so the PI sought to engage these persons from the South Cove center to promote these interventions.
The project's interventions were:

- To develop a loose network of local businesses, together with a community health center;

- To put together a health education team familiar with the community and its culture to review, adapt, and develop subject material appropriate for the educational level of the target population;

- To successfully implement on-site presentations at the workplace and improve accessibility for project participants; and

- To evaluate the efficacy of the intervention activities.

Program components were designed to be highly flexible in order to accommodate the schedule of business owners and workers.

After obtaining consent from employers, brief (30-40 minutes) presentations were scheduled in two phases at participating worksites. Phase I was a talk and slide show presentation that covered hypertension, cholesterol, smoking, and alcoholism. Phase II included a post-test questionnaire on Phase I topics, followed by a talk and slide show presentation on cancer. Program staff also measured participants' blood pressure, height, and weight, and they passed out supplemental printed materials on topics covered in each phase.

A pre-test questionnaire was designed to survey the participants' habits and self-perceptions and to test basic concepts related to health promotion. All questions were in multiple-choice format and were translated into Chinese characters. The process evaluation included a pre-test and preview of health education materials and interventions with workers. Coalition members reviewed project activities quarterly and semiannually, and the South Cove board was involved in general program review.

III. Project Implementation

The health education team used their materials as needed at each intervention site. Usually, the team would perform outreach by distributing bilingual health newsletters and Asian-language health-oriented brochures. The team then scheduled and made a health education presentation that was carried out in two phases. In the first phase, a talk and slide show presentation was given, followed by measurement of blood pressure, height, and weight, and distribution of information. The Phase II component included pre- and post-test questionnaires in order to capture any changes in knowledge about risk behaviors. The South Cove Center gave 28 Phase I presentations in Chinatown over the two-year OMH project period. Of the 28, 19 agreed to a Phase II presentation. Baseline data on the target population were collected during the project period. However, very little process or outcome information about the health intervention could be determined at the conclusion of the grant period. The health education team also tried to recruit more local businesses to participate in the coalition and related interventions during the project period.

Halfway through the project, the PI left the South Cove Center for another job at the State level. It is not clear what effect his departure had on the project, but by that time, the project was well under way. The coalition, however, did not really establish itself during the project period. First, there appeared to be some turnover in businesses participating in the coalition. Secondly, it was noted that very few coalition members took a lead or participatory role in the planning or implementation of project interventions. Third, the coalition only met a few times during the project period. Despite this apparent lack of involvement, it was still important that the businessmen participated, however peripheral their involvement may have been. They played important roles as influential forces in Chinatown, and they provided the space and time for their employees to participate in the intervention. One coalition member, the owner of the largest Chinese restaurant in Chinatown, participated in the health education by posting "No Smoking" signs in a section of his dining room and in the kitchen area. He required his employees to participate in the South Cove presentation before they could take their lunch break.

Even though the coalition no longer continues, the connections South Cove made with the business community provided a gateway for future communication between the health and business interests of Chinatown--a compliment to the working relationship established during the OMH grant period.

IV. Project Outcomes

Most of the stated project objectives were achieved during the project period. It is important that the project was able to reach an otherwise difficult-to-access population, yet it is not clear whether this type of health promotion has led to any measurable changes in high-risk behavior. This project was unique in its approach to the target community. The program staff were able to negotiate with restaurant owners (i.e., Chinatown power brokers/businessmen) in order to conduct health education sessions at the target population's place of work. This provided a greater chance of meeting those most in need of health education and risk-reduction education.

There appeared to be poor documentation on the follow-up of those who were found to have elevated blood pressure, and the attrition rate during Phase II of the project reached 58 percent.

The project produced a bilingual video on cancer awareness and nutritional issues that highlighted Chinese nutritional habits and their relation to health and cancer. The OMH grant also provided the South Cove center with the means to translate health information pamphlets and to upgrade their slides and presentations.

The South Cove Center sought to continue grant funding from other sources, but it was unsuccessful for this particular project. The center was successful, however, in obtaining funding for other community health service delivery. The South Cove Center now holds free screening at two annual events in order to promote its cancer awareness and health education agenda, and the pamphlets and information materials developed during the OMH funding period are still being used in conjunction with current health intervention activities.

Spread Effects

Although the coalition was discontinued, an important step was accomplished during the process. The coalition brought together people from varied sectors of Chinatown to address a community health problem, and the process of coalition-building took hold in the Boston Asian community for the first time. The program staff from South Cove established contacts in the community that could provide a gateway for future health initiatives, and this project helped lay the groundwork for the Asian community's involvement as the Chinatown Coalition in the Healthy Boston Initiative.

V. Lessons Learned and Suggestions

The project's coalition and program staff members provided the following experience-based perspectives and suggestions for other projects and OMH.

Lessons Learned

- Entry into this community depends upon already-established networks of social and personal relationships. It is important to be sensitive to people's time and livelihood.

- Respect and attention should be paid to individuals within the community who are perceived as knowledgeable professionals (e.g., teachers, doctors).

- Visual presentations and direct interaction with the target community are highly effective strategies for this community.

- Despite the fact that service delivery to this target community is difficult to carry out, the program showed considerable flexibility in its approach to project interventions while being sensitive to time and business concerns.

Suggestions for OMH

- The coalition and staff members felt that OMH could be more responsive to the grantee by maintaining consistent or regular contact throughout the project period.

- The grantee would like to see OMH involve experienced minority representatives in drafting the RFA and application guidelines. Further, the Federal government should cover the cost of translation services for documents that outline Federal regulations or grant guidelines for people who speak languages other than English.

- Projects that operate cost effectively should be rewarded. If the grant money is unused at the end of the grant period, be liberal with no-cost extensions.

- Grantees should be funded directly, not through state or health departments, if this may be an obstacle to project implementation.

- Flexibility should be allowed in project staffing.

The El Paso Coalition for Hispanic Health Promotion Project
El Paso, TX

In 1987, OMH made a two-year community health coalition demonstration grant award to the Paso del Norte Area Health Education Center in El Paso, Texas, to develop a health education/risk-prevention program for the El Paso Mexican American adult population at risk for diabetes.

I. Context

The Setting

The city and county of El Paso lie at the westernmost point in Texas, directly south of Las Cruces, New Mexico, and immediately north across the Rio Grande River from the large city of Juarez, Mexico. An estimated 73 percent of the local population is composed of Hispanics, the vast majority of whom are of Mexican heritage; Mexican Americans constitute approximately 62 percent of the population of the city of El Paso and 67 percent of the population of the surrounding county.

The Community

El Paso's Hispanic heritage dates back more than 300 years, and its rapidly growing, predominantly Mexican American community includes families that have resided in El Paso for lengths of time that range from centuries to decades to a few days. This variation is reflected in the different degrees to which people may identify with Mexican and/or American society and speak Spanish and/or English. Nonetheless, the proximity of the populous city of Juarez and the Nation of Mexico ensure that Mexican cultural values and customs remain strong in El Paso's Hispanic community and continue to influence health- and diet-related perceptions and behaviors, including the use of clinical and folk medicine.

On the whole, the poorer elements of El Paso's Hispanic population are engaged in low-wage occupations and have a low literacy rate. Unemployment and underemployment are prevalent, and 25 percent of the county's population lives below the poverty level. The majority of this population lacks ready access to private or public health care services.

Health Status

Mexican Americans have been shown to be at five times greater risk than the general U.S. population for adult onset of diabetes mellitus. A number of factors predispose Mexican Americans to diabetes: body mass index, weight at onset of diabetes, frequency of positive family history for diabetes, a genetic predisposition toward diabetes shared by

Native Americans and Mexicans of full or partial Amerindian descent, and diet. In a study of diabetes in 17 Texas counties, El Paso had the highest incidence.

A majority of El Paso's poorer Mexican Americans derive from rural communities with lifestyles characterized by strenuous agricultural labor and diets in which animal fats are deemed a luxury, and therefore greater body weight is generally considered a sign of relative well-being and prosperity. In El Paso, the comparatively sedentary nature of urban life, the use of lard in the preparation of traditional dishes, and a diet largely composed of simple carbohydrates and prepared foods high in saturated fats are, in combination, highly conducive to increasing obesity with age. Within the low-income Mexican American population, obesity per se is not viewed as unhealthy. Diabetes is generally not well understood, and, as with other ailments, symptomatic relief is frequently sought through the use of herbal remedies. Further, many persons have undocumented immigrant status and hesitate to seek health services. Access to primary health care was extremely limited during the project period and remains so due to a lack and poor distribution of existing health facilities. These constraints militate against the prevention, early diagnosis, and management of diabetes in this community.

II. Project Initiation

Antecedents

The El Paso Health Issues Forum, an informal multiethnic association composed of a variety of local health care and social service organizations, was formed in the early 1980s to explore ways to address the many health-related problems--including diabetes--confronting the city's low-income residents. Upon learning of the OMH Community Health Coalition Demonstration Grant Program, this association's members formed a formal coalition and secured an OMH grant to launch the Paso a Paso (Step by Step) Diabetes Prevention Project. The lead organization in this effort was the Paso del Norte Area Health Education Center (AHEC), a nonprofit organization (associated with the Texas Technical University Health Sciences Center, El Paso) that was founded in 1986 for the purpose of improving the supply, quality, distribution, and utilization of health personnel in the region, with particular attention to developing programs to help meet the health care needs of El Paso's low-income Mexican American population.

Organization

In the capacity of grantee organization, the AHEC lent the coalition two specific advantages. First as a non-service-delivery entity, it provided neutral ground for cooperation among sometimes competing health provider organizations. Secondly, its board of directors included representatives of major local health care delivery and training institutions with the capacity to facilitate access to and for the target community, as well as to contribute consultant expertise, financial assistance, and information dissemination support to the project. In addition to the AHEC, the coalition board's organizational

representation included a medical school and its affiliated teaching hospital and ambulatory care clinic, a nursing school, a community health center, and the local diabetes association. In response to OMH's expressed concern that the coalition should represent a broader spectrum of organizations including more community-based entities, an adjunct advisory committee was formed that consisted of local representatives of State and city health and educational agencies, the local community college, churches, and a number of community-based clinics and other organizations involved in a range of health promotion/risk-reduction programs geared toward low-income Mexican Americans. The combined membership of the coalition board and advisory committee was 85 percent Hispanic. The coalition's mission was to make decisions and policy for the overall project and to provide supervision for the intervention program.

The program's core staff consisted of a full-time program coordinator responsible for program management, curriculum development, staff training, record keeping, and program evaluation, together with two part-time persons who served as health educators. All three were bilingual Mexican Americans familiar with the culture and health-related perceptions and behaviors of the local community, and they possessed combined expertise in the fields of medical anthropology, public health, and social work.

Design

The project's goal was to develop a community-based health promotion program targeting low-income Hispanics over 30 years of age whose lack of exercise and diet placed them at risk for obesity and the development of diabetes. The project's objectives were:

- To form and maintain a health coalition,
- To develop and pilot test a diabetes awareness and weight-reduction program for at-risk persons,
- To carry out eight-week courses for up to 400 at-risk persons,
- To establish an assessment and referral system for at-risk persons, and
- To conduct educational training for a core of professionals and lay persons to reinforce and continue the public education related to diabetes risk reduction.

Process evaluation plans called for the compilation and periodic review of monthly progress reports and coalition meeting minutes, notes, and records, together with the use of a patient satisfaction questionnaire and a quality-assurance plan. Outcome evaluation design entailed monitoring 10 percent of the program participant sample from start to finish, to include pre- and post-participation physical examinations and oral and written interviews to assess health status behavioral change, weight control, body image, diet recall, and mental outlook about risk reduction, health promotion, and diabetes.

At the outset of the project, a needs assessment was conducted; this involved carrying out discussions with six community focus groups. The results of this needs assessment accomplished the following: formed the basis for setting viable, realistic project goals and objectives; ensured that the project would reflect and address community concerns rather than the agendas of coalition member organizations; realigned coalition member focus and roles away from organizational turf-based issues toward project-objectives-oriented functional task areas; and provided content and direction to the development of the intervention program.

The program was designed to focus on establishing group support systems at the neighborhood level by using existing family and social networks to help create a social environment conducive to exercise and improved eating habits. Materials would be developed (and tested) in Spanish and English, and intervention instruction would be conducted by professional bilingual individuals who had worked in Mexico with third world models of health education and health promotion. The materials would be designed to be oral and interactive, based on the Mexican American oral tradition, which transmits important attitudes, values, and messages through proverbs, stories, music, and humor.

III. Project Implementation

The program's activities encompassed the following:

- Health promotion efforts entailed community health fairs, public media announcements (in Spanish and English), and distribution of written materials, including posters, radio dramas with companion booklets, brochures, and flyers,

- Recruitment of education program participants, screening, referrals, and the conduct of eight-week classes took place in the city's clinics, where 436 individuals took part in the pilot education program, and an additional 300 participated in a second round,

- Participant-maintained individual records on exercise level and weight measurement, neighborhood walking clubs, and program-logo T-shirts and bumper stickers served as incentives to maintain active program participation.

During the second year of OMH funding, in realization that a method other than grant funding would probably be needed to extend the life of the program, the program staff drew on their familiarity with various health promotion models, in particular Freirian pedagogy, to formulate their own community health promoter model to recruit 60 former education program participants to serve as volunteer community health workers. The role of the community health workers was to help identify individuals at risk, promote participation in exercise, monitor program participant weight loss, provide nutrition information, and make referrals in cases requiring diabetes management. Upon completion of a certified training course in exercise promotion, health and nutrition

education, CPR, and teaching methods and communications skills, these community health workers proceeded to conduct education programs for approximately 2,500 members of the community (the community health workers purposely did not keep records on the number of program participants because they did not want to appear to be motivated by self-aggrandizement rather than concern for neighbor and community). There was no numerical goal as to the number of community health workers who would be trained, since the objective was only to ensure mere survival of the eight-week prevention program. When the curriculum for the training was developed, institutional backing was sought through the El Paso Community College Continuing Education Department. It became part of the college curriculum and resulted in more than five cohorts of community health workers receiving training.

The composition and roles of the program staff remained essentially the same during the project's implementation phase. The staff and the community health volunteers worked closely together in carrying out program activities, and program participants provided continuing input during the process. Attention was given to ensuring the flexibility and cultural appropriateness of all aspects of the implementation phase, including the development and testing of written materials and the inclusion of local community members in audiovisual presentations, the methods used for information dissemination, the selection of intervention sites, the use of incentives, and the recruitment and training of community volunteers. The community health workers played a central role in shaping the module-based education program curriculum, which underwent a number of refinements to ensure its appropriateness and effectiveness for the local community.

The coalition met on a periodic basis and had two committees, one for planning and public relations, to assist in the development and promotion of the education program (and later to seek continuation funding), and the other for implementation, to facilitate education program implementation at the various community sites. The coalition did not have a chairperson, and therefore the program coordinator was asked to serve in that capacity. Because of the program coordinator's principal focus and many responsibilities, this added function proved burdensome.

The coalition's member organizations made numerous contributions to the project: meeting and activity space, sponsorship of events, health and nutrition expertise in the provision of instruction and review of materials, assistance in the development of written and audiovisual materials, program promotion, and the services of clinical and other personnel in conducting physical examinations and facilitating education program activities.

IV. Project Outcomes

The project reached most of its objectives. The target number of participants in the education program was exceeded by more than 100 percent, and evaluation results showed marked improvement in health knowledge, level of exercise, weight loss, and diet

modification. Yet program enrollment was very uneven by sex; fewer than 10 percent were males. The use of community health workers markedly expanded the number of program participants and played a key role in extending the life of the program. However, efforts to enlist local health care provider organizations to carry on the program in its preventive orientation and to provide coordinated followup and diabetes management services for the target population were only partially successful.

The coalition did not acquire funding to continue the project, and the coalition ceased to exist after the end of the OMH grant. However, the AHEC secured local support to maintain the education program for an additional year.

As of 1993, the health workers were still conducting education programs at a number of sites, and they remained active in their neighborhoods and were extending the scope of their activities into other health areas. As neighborhood associations they were collectively active in various community self-help activities and were meeting with success in pressuring local authorities to provide public sanitation, lighting, and transportation services. Moreover, some of them had since earned high school equivalence diplomas, started college, or enrolled in nursing school. A number of the community health workers participated in the 1992 Tucson Conference on Peer Training, thereby increasing their self-assurance to serve as community resources. They indicated what involvement in the project meant for them: "When I got my certificate, my children came to my graduation, and it felt very good; I never thought something like that would ever happen to me." "By participating in this program, we have learned much, and we like to teach it to others." "This program helped me to gain self-esteem that I never had before; we all have more confidence, and we join together to help our community."

Spread Effects

- As a result of its involvement in the coalition, the El Paso Diabetes Association added several Hispanics to its board of directors.

- The Paso a Paso Diabetes Prevention Project Model was adapted to address other health issues such as cancer awareness, high-risk prenatal care, tuberculosis, and childhood immunization in El Paso's Hispanic community clinics.

- The model was adopted in one New Mexico community health center and in four community health centers in various parts of Texas that provide health care to Hispanics.

- Information on how to implement the model has been provided in response to requests from more than 60 organizations around the United States.

- Presentations on the model have been made in numerous international and national forums.

- The Texas Department of Health recognized the model with an award and provided a grant for the evaluation of the model in process.

- The U.S. Public Health Service recognized the model with an award.

- The American Association of Retired Persons included the model in a video on exemplary health-related programs for senior citizens.

- The community health worker model was replicated in two health education projects and one community-needs assessment project in El Paso.

- Based on various health-promotion approaches to maternal and child health, family planning, and infectious disease prevention in the young, the community health worker model proved effective in El Paso as adapted to prevention of adult-onset chronic disease. This usefulness in addressing chronic disease, an issue toward which industrializing Mexico has recently turned its attention, attracted the interest of Mexico's Ministry of Health, and aspects of it were adopted across the river from El Paso in Juarez.

- Several community health workers trained by the project have pursued higher education objectives and/or have found paid employment in the health education and promotion field.

V. Lessons Learned and Suggestions

The project's coalition and program staff members provided the following experience-based perspectives and suggestions for other projects and OMH.

Lessons Learned

- Trust is of key importance. This includes both the need to gain the trust of the community and placing trust in the community's perceptions of its needs and ways to meet them, together with willingness to fully engage community members in shaping and implementing any project that affects the community. A community needs assessment should be conducted at the outset, and community leaders and community volunteers should be recruited early.

- Aside from cultural specifics, this project's approach should be replicable in any low-income community. As noted by one coalition board member, "This kind of project empowers people to take command of their own destinies in many little ways."

- Flexibility and inclusiveness are crucial in program design and implementation. It is necessary to experiment and mix components in order to create new products that are culturally appropriate and effective for the community concerned.

- Excellence should be the goal. Health promotion and education projects should aim for the highest caliber of performance and outcome.

Suggestions for OMH

- Adequate funding is needed for the continuation of successful projects.

- It would be helpful for OMH to disseminate more information about the projects it funds.

The Ayude Su Corazon/Help Your Heart Coalition Project
Sacramento, CA

In 1988, OMH made a two-year community health coalition demonstration grant award to the Hypertension Council of the American Heart Association, Golden Empire Chapter, in Sacramento, California, to carry out a heart-disease education program focusing on the cardiovascular risk factors of hypertension and diet in the Hispanic population of Yolo County.

I. The Context

The Setting

Yolo County lies just to the west of Sacramento in California's agriculturally rich central valley and contains in addition to the university community of Davis, the predominantly rural small towns of Esparto, Knight's Landing, Madison, Woodland, Winters, and Yolo. The ethnic composition of these six towns is predominantly white and Hispanic, with the proportions of the latter ranging from 35 to 90 percent.

The Community

In 1987, Yolo County's Hispanic population numbered 16,147 persons. The great majority of the county's Hispanics are of Mexican origin and include former migrant farmworker families that have settled in this area in recent decades and engage in local agriculturally-related work, together with current migrant farmworkers and family members from elsewhere in California and north-central Mexico who reside in the county for varying lengths of time according to season, crop, and labor demand.

Given the seasonality and generally low pay that characterize agricultural work, Yolo County's Hispanic population is relatively poor on the whole. Many, especially older persons and migrant workers and their families, have had limited formal education in either Spanish or English, and a considerable proportion of them speak little or no English.

Over the past 20 years, the Hispanic communities in the six towns have become firmly established and cohesive, with Catholic churches serving as focal points of social life. Cultural and social ties with Mexico remain strong. Traditions involving language, religion, festive occasions, music, food, and folk medicine are maintained, as are social mores governing the respectful conduct of youth toward their elders and the differentiation of gender roles, including health-related perceptions and behaviors.

Health Status

Heart disease continues to be the leading cause of death throughout the United States, including California. For 1986, California Department of Health Services data and Yolo County vital statistics identified heart disease and stroke as the cause of 42 percent of county deaths. The 1987 California State Hypertension Survey showed that, among all ethnic groups, the Hispanic population--including that of Yolo County--exhibited the lowest awareness of the dangers of elevated blood pressure and high cholesterol and their relationship to heart disease and stroke, and Hispanics were also found to be least likely to be under medical treatment for the management of hypertension. Church site screening in two Yolo County towns revealed that 20 percent of those examined (especially Hispanics) had elevated blood pressure, and that most participants in the existing Hispanic church blood pressure programs had not had their blood pressure checked on a routine basis. Spanish written materials concerning health and nutrition were found to be unavailable in these communities. Consonant with their traditional domains and family responsibilities, Hispanic women as a whole tended to demonstrate some knowledge regarding these health- and diet-related issues, together with interest in addressing them, whereas young Hispanic men generally evidenced a lack of familiarity with these matters and little involvement in preventive and management programs.

II. Project Initiation

Antecedents

These factors affecting the health of the local Hispanic population attracted the attention of the Health Education Council, a Sacramento-based unincorporated multicultural community health education organization. The Health Education Council staff met with representatives of the town of Winters, and a cardiovascular health promotion/risk reduction program called Ayude Su Corazon (Help Your Heart) was formulated for the town's Hispanic population. It would comprise risk-factor education, screening and referral, and resource development, and it would also include a community advisory committee providing office facilities, church screening space, volunteer support, sponsorship of events, and program advertising. In 1988, under the aegis of the Golden Empire Chapter Hypertension Council of the American Heart Association, the Health Education Council secured private-sector funding to launch the program. This generated such great interest throughout Yolo County's Hispanic population that soon a multicommunity coalition was established and an OMH grant was awarded to expand the prevention program to five additional towns in the county.

Organization

The project's coalition was based on the membership of local community advisory committees, and its 30-member board included organizational representatives and individual members. In addition to the Health Education Council, the organizational

membership comprised four churches, two voluntary health entities, two migrant health clinics, one migrant farmworker camp, and three local government agencies. The four individual members were recognized leaders in the Hispanic community. Cooperating organizations included additional churches, local businesses, and other community-based entities, the county health department, and local hospitals, school systems, and universities and colleges. The coalition board was 80 percent Hispanic in composition. The coalition's mission was to provide guidance, support, and assistance in implementing a bilingual communitywide health education campaign and for its members to render volunteer assistance in the areas of training and health screening.

The project's program staff was composed of a director the Health Education Council director, at 50 percent time, a full-time program coordinator (a bilingual physician from the part of central Mexico from which most of the county's Hispanics had come), and a half-time bilingual program assistant. Community volunteers were recruited through the respective local advisory committees to support screening functions and, after training, to take blood pressures.

Design

The project's goal was to conduct a Hispanic-oriented coalition-based heart disease education program in six rural communities. The project's objectives were:

- To educate Yolo County Hispanics regarding the dangers of uncontrolled high blood pressure and dietary habits as they relate to cardiovascular disease;

- To screen at least 65 percent of Hispanic adults (5,000 persons) for blood pressure and cholesterol, recheck and refer them for care if necessary, and later contact them to determine referral outcomes; and

- To develop local community resources to ensure that health coalition activities become self-sustaining.

Crucial to project design were Hispanic community leader commitment and local advisory committee input. The project's flexible approach for engaging Hispanic population segments called for initiating health education and screening activities in a variety of settings appropriate to the culture of the community: churches, schools, grocery stores, bars, migrant farmworker camps, and other local community locations in the six towns. In this regard, young males (ages 18-44) were targeted as a group whose participation would require greater effort and innovative outreach to such locales as migrant camps, bars, and poolhalls. Primary school students were targeted for preventive health education.

The project's evaluation plan entailed the following: a baseline study to determine community knowledge about high blood pressure, cholesterol, and risk factors; a before-

and-after survey of a subset of the community to measure indicators of knowledge about cardiovascular disease risk factors; followup surveys of schoolteachers and grocery store owners to assess the program's influence on community knowledge and dietary patterns; measurement of the scope and frequency of continuing health screening activities carried out by trained community volunteers; and an inventory of community resources.

III. Project Implementation

The program's activities encompassed the following:

- Cardiovascular education: production and dissemination of bilingual information through four semiannual newsletters; articles in local ethnic news sheets, church newsletters, and newspapers; radio and television public service announcements; an educational program for elementary school students and take-home materials for parents; and grocery-store-based health education dissemination through taped messages and diet information stuffers.

- Screening: development of a bilingual blood pressure measurement manual; training of more than 60 community volunteers in blood pressure measurement; multisite screening, referral, and follow-up; and provision of cholesterol screening through a local hospital.

- Resource development: creation of a volunteer Hispanic blood pressure screening network; maintenance of the Heart Education for Youth program; and identification of community leaders and key organizations to continue the coordination of Hispanic heart disease education and screening activities.

The program staff's composition and roles remained the same during the implementation phase. The staff and community volunteers worked closely together in carrying out program activities, and local advisory committee members and program participants provided continuing input during the process. Attention was given to ensuring the cultural appropriateness of all aspects of the implementation phase, including the development and testing of bilingual educational materials and the inclusion of local Hispanics in radio and television presentations, the methods used for outreach and information dissemination, the recruitment and training of community volunteers, and the selection of intervention sites.

The coalition board was chaired by a unanimously elected local Hispanic educator and met on a bimonthly basis. During the course of the OMH funding period, the board was augmented by a local university nutritionist and a media expert. The coalition's translation task force--composed of coalition members, local residents, and migrant farmworkers--reviewed all printed and video health education material for cultural orientation, specific language, and reading/comprehension level. The coalition board was involved in the

development of all program elements, approved them prior to implementation, and periodically reviewed their progress.

Coalition contributions to the project included the provision of local office facilities and meeting and activity space, sponsorship of events, and advertising. Also, 25 coalition board members served as volunteers in facilitating blood pressure screenings, including the training of community volunteers and the conduct of screenings, referrals, and followups. Moreover, at no cost to the project, the local media helped it to gain public exposure, and local university faculty lent expertise to the project in the areas of nutrition and program evaluation.

IV. Project Outcomes

The project achieved most of its objectives. The Ayude Su Corazon/Help Your Heart education campaign reached all of the county's Hispanics, and study results showed that their knowledge of cardiovascular disease and associated risk factors markedly increased over the course of two years; 4,000 (out of a targeted 5,000) persons were screened for blood pressure and serum cholesterol during the OMH grant period; the volunteer Hispanic blood pressure network, composed of more than 50 individuals, continued its efforts and screened an additional 2,500 persons; more than half of the 50 teachers trained to use school-site materials integrated the heart education modules into their ongoing curricula; and community leaders and key organizations continued to coordinate health education and screenings. However, efforts to enlist local health care provider organizations to become a health care resource network providing back-up and followup services for the Hispanic population were only partially successful, and the resource inventory was not completed.

Although no new grant was acquired to continue the project per se, State funds were secured to provide health education in the areas of smoking cessation, HIV/AIDS, and nutrition. As of 1993, the coalition board had an active organizational and individual membership of 18 persons, wrote bylaws, adopted the name of Instituto Regional de Salud (Regional Health Institute), and broadened the scope of its health education mission to encompass a wide range of health issues facing the Hispanic community. The coalition continued to seek funding to support additional health education services for the Hispanic population of Yolo County.

The project gained access to all segments of Yolo County's Hispanic population, and vigorous and innovative efforts succeeded in engaging hard-to-reach young Hispanic males in the program. The local advisory committees were instrumental in institutionalizing the project in their respective communities. Gaining the OMH grant award and successfully carrying out the project enabled the Health Education Council to attain independent status as a nonprofit community-based multicultural entity and provided it with the capacity to address a range of minority health issues, including its current State-funded health education projects on smoking cessation, HIV/AIDS, and

nutrition. The community advisory committees expanded their scope to deal with a spectrum of health issues and other matters of importance to their communities, such as bringing collective pressure to bear to ensure that local elementary schools have Spanish-speaking personnel. Local advisory committee members and community volunteers voiced their positive feelings about their involvement in the project: "It taught me a lot concerning health and nutrition, and I use what I have learned to help my family and neighbors." Further they stated, "Now that we know we can do this, it gives us confidence that we can accomplish other things as well...This experience has shown us how to get organized, how to work together to improve conditions for our community."

Spread Effects

- The hypertension screening program was extended to include white church congregations, thus broadening the project's health impact and improving local interethnic communications and relations.

- As a result of their involvement in the project, some former high school volunteers began formal training in health professions, and local youth trained through the project continued to serve as community volunteers in community-based health-related efforts.

- The program staff and community volunteers made presentations on coalition-building and project implementation in numerous local, county, State, and national forums, and the results of the cardiovascular knowledge study were published in the health education literature.

V. Lessons Learned and Suggestions

The project's coalition and program staff members provided the following experience-based perspectives and suggestions for other projects and OMH.

Lessons Learned

- Health-oriented activities organized and carried out by a coalition composed of community leaders and indigenous volunteers can be effective in reaching and empowering an otherwise underserved community. With alterations to fit the specific cultures and needs of communities, this "indigenous model" would be very applicable to other minority populations in other settings.

- In order to carry out a project that has increased access to health care services as an objective, coalitions should include representatives of the health care establishment who have the authority, or delegated authority, to actually influence and, if necessary, modify the health care system.

- After facilitating the formation of a coalition, the lead organization should immediately start to distribute responsibilities among the coalition membership.

- In addition to requisite professional qualifications and a commitment to improving the quality of life of the community, program staff should be familiar with the community's culture and health-related attitudes and behaviors.

- Flexibility in reaching out to the community is critical in terms both of targeting different population segments and of selecting intervention sites appropriate and accessible for community members (if not for the health care establishment). In the words of one coalition member; "You go to them; they don't come to you."

Suggestions for OMH

- The grant period should be increased to at least three years.

- Funds should be provided for innovative ideas beyond the initial three years.

- Technical assistance should be rendered for evaluation; breakout groups on evaluation should be planned at subsequent grantee meetings.

- Grantees and former grantees should have opportunities to communicate more frequently, e.g., periodic meetings and conference calls.

- A set of basic standardized data collection items should be developed on the demographic characteristics of populations served throughout the country through the Demonstration Grant program.

- Grantees should receive feedback quarterly reports.

- An OMH newsletter should be created and distributed to inform the grantees and former grantees about OMH Coalition Demonstration Grant Program updates and individual project highlights.

The Kansas Black and Hispanic Coalition on Infant Mortality
Topeka, KS

In 1988, OMH made a two-year community health coalition demonstration grant award to the Kansas Department of Health and Environment in Topeka, Kansas, to carry out a project to reduce the incidence of infant mortality and low birth weight within the African American and Hispanic populations of Kansas.

I. The Context

The Setting

Kansas is a predominantly agricultural state in which migrant farmworkers are employed in low-wage seasonal agricultural work, and other unskilled laborers are engaged in low-income jobs in its major cities. The three areas identified for inclusion in the project have high densities of both categories of workers--Kansas City (Wyandotte County) on the State's eastern border adjacent to Kansas City, Missouri; Topeka (Shawnee County), the State capitol, in the northeast area of the state; and Wichita (Sedgwick County), in the southcentral region. Low-income African Americans and Hispanics are highly represented in these three locations.

The Communities

According to the 1980 census, there were 127,170 African Americans and 32,000 Hispanics residing in Kansas. Sixty-seven percent of the African Americans and 78 percent of the Hispanics were located in the three major cities and their surrounding counties. Most of the African American families have resided in the State since the last century. The great majority of Hispanics of Mexican heritage come from families who have lived in the State since the early 1920s, together with more recent arrivals and migrant workers and their families from the Rio Grande Valley of Texas and central Mexico.

The State's low-income African American and Hispanic residents are engaged in low-wage manual labor and are subject to periodic unemployment and underemployment. Generally, the educational level for African Americans ranges from 10th to 12th grade. That for Hispanics is less. The more recent Hispanic arrivals converse almost entirely in Spanish and speak little or no English, and many utilize traditional folk remedies to treat illness. For the members of both populations, poverty prevents access to private health care, and to varying degrees social and cultural barriers and the undocumented status of many Hispanics restrict their access to public health services.

Health Status

Public health statistics for 1986 revealed that in the three cities and their surrounding counties, there were 2,345 African American births and approximately 700 Hispanic births. Infant mortality and low-birthweight rates for African Americans were more than twice those for whites, and infant mortality rates for Hispanics were 33 percent higher. Moreover, health indicators led to estimates that 26 percent of the African American mothers and 45 percent of the Hispanic mothers received marginal or inadequate prenatal care. It was noted that these women were generally young and single, had previous pregnancies, and were largely unemployed or held marginal jobs. Public health officials and providers postulated that many of these young women did not seek prenatal care because of insufficient finances, mistrust of the health care system, and avoidance of anticipated discrimination.

II. PROJECT INITIATION

Antecedents

In recognition of the urgent need to address the health care needs of this at-risk population, state officials and representatives of voluntary and community-based organizations formed a coalition and sought an OMH community health coalition demonstration grant. This initial effort failed but, after enlisting technical assistance from the Public Health Service Region VII Minority Coordinator, a subsequent application was submitted and an OMH grant was awarded in 1988 to conduct a low-birthweight prevention outreach project for young, pregnant African American and Hispanic women. The Bureau of Family Health of the Kansas Department of Health and Environment (KDHE) initiated this endeavor and was the grantee organization.

Project Organization

In addition to KDHE, the coalition's member organizations were city or county health departments in the three target communities, local school systems, churches, and nonprofit entities. The coalition board included 10 African Americans and four Hispanics. The coalition was to play an administrative role in the project and assigned itself five tasks; determine the health environmental factors existing in the three target communities, determine the methods to be used in the reduction of the risk factors, identify experienced community leaders working on health issues and other community concerns negotiate with influential community institutions and providers to decrease barriers to adequate and appropriate health care delivery, and identify funding sources for the continuation of grant activities beyond the two-year OMH funding period.

The program staff numbered six: three part-time--a director (who was the director of the KDHE Bureau of Family Health), a coordinator, and an office assistant--and three full-time community health educators (CHE's) to provide local public health department outreach

services in the three target communities. Two public health nurses were assigned as resource persons, they supervised and gave technical support to the CHE's. According to the PI, their contributions were invaluable to the project. The staff was composed of four African Americans, one Hispanic, and one white American.

Design

The project's goal was to reduce the disparities between African American and Hispanic infant mortality and low-birthweight rates and those of whites and to increase access to and utilization of existing health and social programs by at-risk African Americans and Hispanic women. The project's objectives were:

- To raise community awareness and provide information on risk factors through public media, focus groups, and home visits;

- To target 200 pregnant African American and Hispanic women for education and interventions and provide outreach to them through informal social networks and family ties; and

- To develop referral linkages to community resources and facilitate the women's access to and utilization of prenatal and other health and social services.

The project design called for the CHE's to be stationed in local health departments and to provide outreach, educational, and linkage services to at-risk women. Attention was given to the cultural appropriateness of program components through the use of community members to define intervention approaches, the preparation and evaluation of bilingual informational materials, and the employment of CHE's familiar with the culture and health-related perspectives and behaviors of the communities in which they would work.

Project evaluation called for the conduct of a process evaluation, as well as an outcome evaluation, through the gathering of baseline data on a 10 percent sample of the program's targeted participants and the tracking of their physical, attitudinal, and behavioral status over the course of two years.

The process evaluation was based on minutes of monthly meetings prepared by the coalition, case study reports prepared by the CHE's, and interviews. The outcome evaluation was based on a review of client records (intake forms) and followup interviews with clients.

III. Project Implementation

The program was implemented according to plan, but modifications had to be made:

- At the outset, it was discovered that insufficient funds were available to place CHE's in all three target locations, and therefore it was decided to not place one in Topeka in the likelihood that the location of the project's center in that site would be sufficient to draw at-risk participants. Instead, one monolingual African American woman was placed in Kansas City, and a bilingual Mexican American woman and an African American man with Spanish-speaking ability were located in Wichita.

- It soon became apparent that the planned use of informal community networks to reach potential program participants would not be feasible, because this at-risk population's social ties were often attenuated or nonexistent. Further, it was revealed that many of these women moved frequently or lived in homeless shelters, or even under worse circumstances. Moreover, a considerable number were found to use drugs, which, combined with inadequate nutrition, increased the risk of low-birthweight deliveries; their fear that their substance abuse might be detected further reduced their inclination to seek prenatal care. These factors markedly increased the difficulties of the CHEs' outreach and referral activities.

- The placement of CHE's in local public health departments to carry out outreach and coordination functions was complicated by friction between the state and the city or county health departments. This was caused on one side by perceptions of local insensitivity in the treatment of African Americans and Hispanics and was generated on the other side by resentment of state infringements on local autonomy. It was resolved that overall supervision of the CHE's would be conducted by the program director from a distance and that local public health nurses (resource persons) would have responsibility (and receive funds) to render on-site supervision.

The program staff maintained the same composition and roles during the implementation phase. The process and outcome evaluation were conducted by a medical anthropology consultant.

The coalition board met on a monthly basis in the beginning, and bimonthly thereafter, in Topeka. The board chairperson was elected, and the same well-known Topeka African American leader held this position throughout the project. The coalition had three active committees: the public awareness subcommittee was responsible for developing program information and materials and disseminating them through appropriate channels; the program incentives subcommittee was responsible for providing gifts and other incentives to program participants; and the finance committee was responsible for developing funding for continuation of the project beyond the OMH grant period. Participation on this

coalition represented the first time that its African American and Hispanic members had formally worked together, and in the beginning some misunderstandings arose due to the concern of some Hispanics that the project was geared more to the benefit of African Americans than Hispanics. Over the course of time, some Hispanic members left the coalition, and others took their place.

The coalition members and their respective organizations provided valuable incentives in the forms of such items as quantities of infant formula and lined plastic diapers to encourage at-risk women to participate in the program.

IV. Project Outcomes

Despite numerous difficulties, the project achieved most of its objectives. Due to a lack of outreach services, the Topeka Health Department did not reach any at-risk women. However, the CHE's in Kansas City and Wichita were able to reach the target of 200 persons and to gain them access to prenatal and other health care and social services. By the end of the two-year period, the rates of African American and Hispanic infant mortality and low-birthweight deliveries had been reduced. Moreover, the strong advocacy of the coalition with the Secretary of KDHE and other government officials led to important changes in the sensitivity with which African Americans and Hispanics were treated in the three county health departments. Significant modifications were made in administration, policies, and personnel, including the replacement of health department directors, the hiring of African American and Hispanic staff, and the utilization of Spanish-speaking translators.

KDHE now earmarks $160,000 annually for the continuation of limited outreach services in Kansas City and Wichita, as well as a part-time health educator in Topeka. The coalition was transformed into the Multi-Ethnic Advisory Commission on Health to assist the Secretary of KDHE in identifying health problems of African Americans, Hispanics, and other ethnic minority populations, and in recommending appropriate strategies for addressing them.

The African American (non-Spanish-speaking) female CHE proved capable of successfully overcoming cultural and linguistic barriers in reaching out to Hispanic women in Kansas City. The African American (moderately Spanish-speaking) male CHE was likewise able to bridge both cultural and gender barriers in reaching out to at-risk Hispanic women in Wichita.

Bureaucratic, attitudinal, cultural, and linguistic barriers to health care access were reduced in the Kansas City/Wyandotte and Wichita/Sedgwick health departments through the forceful advocacy of the Board members and the two resource persons as well as through the effective outreach efforts of the CHE's.

Spread Effects

- Through the efforts of the coalition, the health department in Garden City, which has many Hispanics and Asians in its catchment area, made the same kinds of administrative, policy, and personnel changes as the other three county health departments.

- KDHE began to target funds to county health departments and to community-based organizations to reward the initiation and maintenance of culturally sensitive programs and behaviors. Moreover, KDHE began to carefully monitor county health department operations to ensure that funds designated for serving ethnic minority populations are in fact used for that purpose.

- Statewide, twice as many Hispanics were using health department services.

- KDHE's increased rewards for sensitive, respectful behavior (and the concomitant penalization for the opposite) has led to the improved treatment of poor whites by health department staffs.

- Involvement in this project led some coalition board members and program staff to focus on the young males involved in the at-risk status of African American and Hispanic women, with attention to gang, drug, and sex-for-drugs behavior. Related activities included implementation of a prevention program in Wichita, participation in a nationally televised conference on minority youth and violence, and sponsorship of a regional conference on the same subject.

V. Lessons Learned and Suggestions

The project's coalition and program staff members provided the following experience-based perspectives and suggestions.

Lessons Learned

- Volunteer coalition board members can make a real difference in their communities through forceful advocacy and mobilization of organizational resources.

- Health and human services providers serving the working poor must be encouraged to provide access to services on days and at times other than Monday through Friday from 8 a.m. to 5 p.m.

- The empowerment of project outreach staff and poor public health department clients is indeed possible.

- Working together in a multicultural manner is effective; diversity can be strength. Further, this project showed that committed African American outreach workers can work well with Hispanics and that men can work effectively with women. This method can ensure respectful behavior of public health staff toward persons of color and can positively modify their behavior toward other low-income persons as well.

Suggestions for OMH

- Periodic feedback and specific guidance on project evaluation are needed.

- OMH regional minority health consultants represent a valuable resource that should be fully utilized.

PREVAIL: AIDS Prevention Project in the Black Community New Orleans, LA

In 1988, the OMH made a two-year community health coalition demonstration grant award to the New Orleans Department of Health to carry out the PREVAIL AIDS prevention project for the African American community in New Orleans, Louisiana.

I. The Context

The PREVAIL project was initiated with the OMH grant and limited city and State funding in 1988. It was the first organized AIDS prevention effort in New Orleans that specifically targeted racial/ethnic minorities. The goal of PREVAIL was to increase the odds for African Americans in New Orleans to overcome the threat presented by AIDS. It also was intended to extend, expand, and complement the impact of the New Orleans Health Department's AIDS Prevention Program, by offering case management and pre/post HIV/AIDS counseling, specifically targeted to the African American community.

New Orleans, like other major U.S. cities, responded at the onset of the threat of AIDS by establishing support networks, services, and prevention programs targeted primarily to the nonmajority homosexual community. This approach to fostering AIDS awareness and risk-reduction behavior was not effective for this predominant African American city. Mortality statistics suggested that racial and ethnic minority communities were either not getting or not utilizing available AIDS awareness and prevention programs. It was believed that special efforts would be needed to reach African Americans in order to affect AIDS-related risk behavior.

The Setting

New Orleans is a city of 550,000 people, 55 percent of whom are African American. According to the Centers for Disease Control, the New Orleans metropolitan area accounts for 74 percent of all AIDS cases in Louisiana. In metropolitan New Orleans, 62 percent of the reported 577 patients have died.

PREVAIL was set up to enhance an existing city government program known as the AIDS Prevention Program. The latter project still goes on and, with PREVAIL, operates out of the same office in New Orleans. The interpenetration of the two programs makes the task of assessing the impact of PREVAIL alone rather difficult. Respondents agreed, however, that there would have been little or no counselling and case management if there had been no PREVAIL. Before PREVAIL, only testing and minimal community outreach was available. The existence of PREVAIL also raised the awareness of Health Department policymakers that there was a need to tailor AIDS programs to the African American culture, something other AIDS programs were not doing and apparently still are not doing adequately in New Orleans.

The Community

The African American population in the City of New Orleans is the target population for AIDS education and prevention activities for this project. The program specifically targeted hard-to-reach persons not usually reached in traditional settings, e.g., persons in housing projects, prisoners, church groups, intravenous drug users, children and adolescents, and young adults. One social worker provided counselling and support services to AIDS patients, persons with AIDS-related complex (ARC), and partners, family, and friends of seropositive persons during the project period.

The New Orleans African American community is characterized by relative poverty, poor health, teenage pregnancy, illiteracy, un- and under-employment, high crime rates, high proportion of female-headed households, and poor access to health services. National figures suggest that African Americans account for approximately 25 percent of all AIDS cases while representing approximately 12 percent of the total population. There is evidence that a similar statistical paradigm exists with respect to the number of AIDS cases reported in the city of New Orleans. AIDS cases in the city are occurring nearly three times more frequently among African American males than white males and 14 times more frequently among African American women than white women. One may therefore conclude from this data that this community is not being reached adequately with AIDS education and risk-reduction information.

Health Status

The city of New Orleans minority population health status is characterized by high incidences of cardiovascular disease, diabetes, cancer, infant mortality, "black-on-black" violence, and substance abuse.

The coalition was intended to enhance the project through each member's expertise and resources, and the main purpose of the coalition was to serve as a community-based support system for the PREVAIL project's efforts. PREVAIL planned to implement an intensive network of HIV/AIDS health education, outreach, and intervention services to the target community. The PREVAIL coalition gave its expertise in the development of culturally appropriate communications and risk-assessment materials, as well as in the development of counselling and other support services.

II. Project Initiation

Antecedents

An integrated network of public and private health care providers gave comprehensive services for persons at risk for HIV/AIDS prior to the OMH grant. They included the Metropolitan AIDS Advisory Committee, New Orleans AIDS Project, Charity Hospital of New Orleans, Desire Narcotics Rehabilitation Center, and the New Orleans Health

Department's Delgado Clinic. The PREVAIL coalition was apparently formed after the OMH grant was awarded.

Getting the attention of the target population was not an easy task. Consequently, an initial impact was not observable in the overall incidence and prevalence of HIV/AIDS in the city. Close monitoring of the early implementation of the AIDS Prevention Program, combined with the community's response, led the New Orleans Health Department to consider revision of the initial program plans. Intervention and case management were identified as needed components of what was an anonymous HIV / AIDS testing and counseling program.

Organization

The coalition came together as a result of the grant application to OMH to fund PREVAIL. The coalition consisted of 13 members representing service providers, gay and lesbian organizations, African American professional associations, and local churches. A core group of about five or eight members actively participated in monthly coalition meetings.

PREVAIL consisted of three components: health education; HIV counseling and testing, and case management. Health education was the pivotal component of PREVAIL and formed the foundation of the intervention strategy. The goal of this component was to reduce the risk of AIDS as well as to increase awareness. The methods used included community outreach, lectures and presentations, classes, and workshops and seminars. Each involved one or more of the following: viewing of audiovisuals, pre- and post-testing, demonstrations, discussions, and theatrical presentations.

Community outreach was the consciousness-raising component of PREVAIL. The two main strategies used were mass media and direct contact with community groups and leaders: door-to-door canvassing in communities where target groups resided; small group discussions in homes; networking with community leaders; lectures/presentations at schools, colleges, and universities; and participation in health fairs.

PREVAIL increased the number of HIV/AIDS testing sites by three and added four staff members to do outreach, health education, and case management services. The AIDS Prevention Project provided equipment, supplies and additional trained staff to three existing clinics. The strategic selection of the locations made nonstigmatized testing easily accessible to many more persons. All locations were staffed with trained physicians, registered nurses, and social workers.

The case-management component was activated after testing and counselling. Together, the client and social worker examined the client's interaction and responses to life events and environments in order to determine the client's needs. From these observations, an appropriate intervention strategy was determined and a case plan formed. Weekly

counselling on an individual, family, or group basis, or a combination thereof, was the main strategy. Support groups were also to be organized.

Design

PREVAIL had two goals: (1) to reduce the incidence and prevalence of AIDS in the African American community by increasing the community's general knowledge regarding AIDS and preventive practices and (2) to curtail the spread of fear associated with the AIDS virus among the African American community. The primary objectives were:

- To provide information regarding AIDS and AIDS prevention to at least 60,000 African Americans in attendance at lectures, symposia, and presentations, as measured by sign-in sheets, audience monthly reports, and pre- and post-tests of AIDS knowledge;

- To convene two coalition planning meetings;

- To meet bimonthly with members of the PREVAIL coalition to ensure needed cooperation and coordination in carrying out PREVAIL goals and objectives;

- To provide handouts and related literature for teachers, mental health groups, and mental health professionals;

- To ascertain the level of knowledge concerning AIDS and its transmittance among selected samples of the African American community;

- To increase the general knowledge about AIDS and its characteristics as a communicable disease; and

- To improve the level of knowledge concerning AIDS and the transmission of AIDS among selected samples of the African American community.

The design of the project took into account lessons learned from mistakes that had been made in marketing ideas, products or people to the African American community. The approach used by the project was a mixture of health education, direct counseling, community- and school-based education, HIV testing and screening, participation in health fairs, and referrals to appropriate medical and counseling programs.

The evaluation design used by the project was the CIPP model (context, input, process, and product; Stufflebeam, 1971), and the evaluation was to answer a set of preselected questions. The final report concluded that 80 percent of objectives were achieved but did not provide supporting data from the evaluation.

III. Project Implementation

Four full-time staff members were employed by the project--a program coordinator, one caseworker, and two health counselors. There were also seven half-time staffers and 13 others contributing between 3 and 20 percent of their time to the project. Consultants were also used to address specific needs. The services offered included HIV education, testing, counseling, case management, and referrals to other social services. The project demonstrated the need for special targeting to African Americans in order to raise AIDS awareness and promote HIV prevention, early intervention, counseling, and referrals. Client records showed considerable increases in the number of PREVAIL clients served over the past couple of years.

The fact that the grantee was the city Health Department put certain limitations on services, e.g., project/program services were limited to Monday through Friday, 9 a.m. to 5 p.m.; potential clients may have had a negative attitude toward a city government agency; and people may have been less likely to volunteer for a city government agency than for a community-based or nonprofit social service agency.

The project had only one or two volunteers for outreach and relied mainly on paid staff to distribute condoms in well-baby clinics, schools, and a few progressive Protestant churches. The level of participation of mainstream churches was less than the staff anticipated. The Nation of Islam was the most active religious organization and a representative from the Nation of Islam served as a member of the coalition. In exploring the constraints faced by PREVAIL in attracting volunteers, the following reasons were suggested by PREVAIL's single volunteer: people don't like the city government; the hours that PREVAIL operates are inconvenient for working people who might wish to volunteer; the government tends to be seen as a provider, not an organization in need of volunteers or other assistance from the community; people in the targeted African American communities are poor and lack spare time to volunteer their services; and people are too busy trying to make a living and taking care of their families.

Printed materials were pretested mainly among staff and coalition members. A local African American artist painted the pictures used for the HIV/AIDS posters, making a significant contribution to the project.

IV. Project Outcomes

A total of 348 clients were tested and counseled in 1989. The cumulative total through October 1992 was 2,163 clients. An estimate of 43,000 or more of the target population was reached through health education directly. Some 241,519 were reached indirectly through the mass media. AIDS awareness in the African American community was unusually low at the time of project start-up, in part because African Americans in New Orleans regarded AIDS as a disease of white, middle-class, homosexuals and one to which they were immune. In addition, there existed unusually strong taboos against

admitting or discussing male homosexuality, as well as discussing intravenous drug abuse and any kind of sexual behavior among many African American audiences, particularly in the churches.

There were genuine constraints to enlisting the cooperation of churches in AIDS prevention and education efforts. The two major churches in New Orleans are the Catholic and the Baptist. The Catholic church has been and remains non-responsive to overtures from PREVAIL staff. A few Baptist ministers have in recent months begun to cooperate with the program and allow AIDS-preventive education to occur in their churches. It was suggested that some of the more receptive Protestant ministers could play a role in enlisting the support of their fellow clergy, which would relieve some of the burden from PREVAIL staff.

The city of New Orleans continues to fund PREVAIL even though it does so at a lower level than the OMH funding. The number of testing sites has been reduced to two, with a corresponding reduction in staff and outreach activities. The case-management component of the program has been discontinued. The coalition now meets as the need arises.

The plan to establish support groups of family and partners of persons with AIDS did not materialize because African Americans in the community preferred to talk about AIDS on a one-on-one basis rather than in a group. However, African Americans in the same community apparently joined 12-step support groups such as Alcoholics Anonymous and Narcotics Anonymous, indicating that perhaps the right approach has simply not been found.

Judging by the increasing "demand" for counseling services, it appears that there is a need for HIV-related support groups. According to the local paper, there are currently three or four support groups for those who have tested positive for HIV. These informal discussion groups focus on issues including health, identity, sexuality, spirituality, and HIV, among other things.

Some among PREVAIL's staff have not been able to attempt further community outreach due to lack of funds or other resources. In the opinion of the community outreach worker, the people most in need of PREVAIL's services are the addicts, prostitutes, and other street people who seldom, if ever, attend church services or social club meetings. The staff's vision for reaching those in the community who most need the services includes conveying information via community forums, conducting neighborhood outreach at housing projects, and increasing awareness among those involved in African American social and service clubs.

Spread Effects

- PREVAIL has added AIDS testing, counseling, follow-up, and referral to a city hospital for early intervention treatment for the city's Health Care for the Homeless program. For about one year, the homeless and poor of New Orleans have been able to receive AZT and other antiviral drugs free. This includes HIV-positive people before they are symptomatic. Some homeless people (as well as others in the African American community) are fatalistic when they learn that they are seropositive, making comments like, "I'm going to die of something. Why not AIDS?" However, considering that follow-up with homeless people is especially difficult, the record of seropositive homeless people returning for further services is encouraging.

- St. Bernard Health Clinic, one of the original project sites (not currently providing HIV testing and counseling), would like to train its own staff to provide PREVAIL services. It has the client base (low-income city housing project and surrounding community) to justify providing these services on a full-time basis with in-house staff.

- Gust High Rise, a predominantly senior-citizen housing project and another former PREVAIL site, continues to organize annual health fairs for residents and the surrounding community. HIV testing and follow-up counseling are among the services provided.

V. Lessons Learned and Suggestions

The project's coalition and program staff members provided the following experience-based perspectives and suggestions for other projects and OMH.

Lessons Learned

- Churches in New Orleans were very reluctant to become involved with AIDS-related activities because of the stigma against homosexuality. The stigma was also prevalent in the community. For example, a woman whose son died of AIDS told people that her son was a drug addict rather than let it be known he was homosexual.

- Low-income New Orleans African Americans are very sensitive about being spoken down to by middle-class-appearing African Americans who wear suits and ties and may have more education. Counselors have found they have more credibility and can be much more effective if they wear "street" clothes.

- There seems to have been some conflict and rivalry between this project and another local AIDS program; this was manifest in turf protection and surfaced as

charges of duplication of services by the latter. The latter program has been operating since 1985, and PREVAIL's first director once worked there. There was some reported unhappiness there when OMH awarded the grant to PREVAIL. Although relations have improved, a legacy of rivalry continues to some extent.

Suggestions for OMH

- The project period should be increased to at least three years.
- Technical assistance should be provided during the application phase, especially with regard to evaluation design.
- Teen pregnancy should be added to OMH's list of priority minority health problems.

Community Coalition to Prevent Black Homicide
Boston, MA

In 1988, OMH made a two-year community health coalition demonstration grant award to the Violence Prevention Project, out of the Boston Department of Health and Hospitals, to carry out the Community Coalition to Prevent Black Homicide (CCPBH) in three urban, predominantly African American Boston neighborhoods: Roxbury, North Dorchester, and Mattapan.

I. The Context

The Setting and Community

African Americans in the three contiguous communities made up (at the time) approximately 70 percent of the population. A needs assessment of the three neighborhoods conducted in 1986 indicated that 39 percent of the households consisted of couples with children, 32 percent consisted of single-parent families, and 8 percent consisted of extended families. Forty-two percent of all households included children under the age of 7 years, 46 percent contained children between 7 and 12 years, and 45 percent contained youths between 13 and 20 years of age. Fifty-eight percent of these households had more than one adolescent.

In 1984, the median income for the target population was $12,000, considerably lower than the citywide figure of $22,000. Forty percent of the target population was at or below 125 percent of the poverty level.

Health Status

Some community factors that presented health risks for this population included severe unemployment and underemployment, poverty, increasing access to drugs, and lack of recreational activities. The target population for this coalition effort consisted of low-income African American youth between the ages of 12 and 21. The target health problem identified was the dramatic increase in violent behavior, particularly homicide, in the community.

II. Project Initiation

Antecedents

The lead agency for this coalition demonstration project was the Violence Prevention Project (VPP), out of the Department of Public Health of the Boston Department of Health and Hospitals. The project is an outgrowth of the Boston Youth program, a comprehensive health-care initiative for adolescents, established in 1982 with funds from the Robert Wood Johnson Foundation. The VPP is a community-based primary and

secondary prevention and education program aimed at curbing interpersonal violence among adolescents. At the time of OMH grant funding, the VPP was working in two Boston communities: Roxbury (predominantly African American) and South Boston (predominantly white). The OMH grant gave the VPP the opportunity to expand outreach and target prevention to three predominantly minority communities in the Boston area: Roxbury, Dorchester, and Mattapan.

Organization

Through contacts previously established in the Roxbury community, the CCPBH was established. The CCPBH coalition, composed of five community-based organizations (the VPP, a church, a community health center, a multiservice center, and a transition house), was designed to provide a model for the institutionalization of violence-prevention activities in each agency. The project's specific objectives were to integrate violence/homicide-prevention education into currently operating programs, investigate new areas for the introduction of such education, and mobilize a broad base of support for this and other homicide-prevention activities through the coalition. The coalition brought focus to the plight of young people in these communities.

Design

In 1983, as part of the Boston Youth Program, a 10-session curriculum focusing on violence prevention and anger management among adolescents was developed by a physician at Boston City Hospital. It was initially used in high school health education classes, and the curriculum has since been used as a foundation in the training of service providers from the city of Boston and beyond. Using the curriculum as the foundation for the work, the project's educators provide violence-prevention training to service providers as well as youth. As many community settings as possible are used to deliver the educational message. Core members of the coalition designated staff within their organizations to receive training in the curriculum and then designed risk-reduction activities that were to become institutionalized within the organizations. Most of the interventions were conducted by the health educator/community trainer. For their part, the coalition members participated in trainings at their specific agencies and met frequently as a group to guide the project.

III. Project Implementation

Throughout the project period, specific interventions included a series of trainings in violence prevention, conducting workshops with teens and adults, providing violence-prevention education materials, developing a camp counselor training guide, and cosponsoring an annual conference on teen violence prevention. To ensure cultural appropriateness, the coalition expanded the curriculum session to address race and socioeconomic status and its impact on violence, discussed African American history and

ethnicity, conducted special workshops to address the specific needs of the target community, and pretested both printed and video materials with youth.

The CCPBH operated out of the VPP office for the duration of the OMH funding period. The first year of the project was marred by a recurring turnover in project and coalition staff. In the first few months, the coalition coordinator was offered a job for the state VPP and left the project. Nine months into the project the coalition and PI hired a new coalition coordinator. A few months after that, the PI resigned to take a new job, and a new PI wasn't hired until six more months into the project. In the meantime, two of the coalition agencies underwent successive changes in coalition representatives, with one of these bordering on nonparticipation in coalition activities. Coalition members and project staff alike characterize the first year of the project as a period of frustration for all. Because of the change in personnel and the difficulty in establishing a solid organizational base for the coalition, project goals and objectives had to be pushed back in order to accommodate these changes.

The coalition struggled with three major issues during the project period: (1) the decision to provide violence prevention over violence intervention (especially in the midst of increasing violence in the three communities); (2) how to actually "coalesce," given the varied nature and missions of each participating agency; and (3) how to institutionalize a violence-prevention curriculum into each respective organization, when there was little support from institutional executives.

Despite these issues and changes in the process of coalition-building, the activities of the coalition produced some very positive results within the community. The coalition fostered a collaboration of diverse community service agencies, which brought varied resources together during the life of the project. The program also had the support of an advisory board of influential community people. The VPP coalition provided a united front among community agencies for addressing the issues of violence in the communities served. The coalition cosponsored an annual violence-prevention conference that dealt with a spectrum of violence-related issues and, most importantly, the coalition informed the community that violence is preventable and capitalized on many media opportunities to get this message across.

The PI hired an evaluation consultant to review all documentation, including written personal perceptions of coalition members, minutes, evaluation forms, data reports, and interviews with staff. Unfortunately, the evaluation was based almost entirely on secondary data and did not adequately capture the dynamic and less tangible aspects of the VPP. The evaluator's comments, however, were reviewed and taken into consideration before the VPP undertook a new coalition.

In 1990, the VPP was funded by the Mayor's Safe Neighborhood Program and was able to expand its service area to include the entire city of Boston. In addition, training and workshop activities included camp trainings, youth leadership programs, and workshops

for medical professionals throughout Boston. The focus of the project has increasingly expanded to include other forms of violence prevention, particularly gang violence.

The OMH project coalition did not continue beyond the project period. However, the idea of a community coalition remained important. Under a five-year Federal grant received in 1990, the VPP, in conjunction with the Massachusetts Department of Public Health, has fostered coalition-building around a broader definition of violence.

IV. Project Outcomes

All institutions implemented violence-prevention risk-reduction activities designed to reach the adolescent constituency. Project interventions helped establish relationships with young people in the community, and the coalition members viewed it as an "investment in change." A cadre of teenage peer educators has been trained to strengthen the prevention and promotion components of the project, and this activity continues. Institutionalization as evidenced by changes in policy, inclusion in mission statements, or the identification of a staff position committed to prevention education did not occur as was hoped.

The integration of violence-prevention education and activities did occur but it was not sustained by all of the organizations. Spin-off activities conducted by other agencies or in collaboration with coalition agencies occurred as a direct result of the coalition. Citywide violence-prevention initiatives began to emerge unrelated.

Some of the positive outcomes of the VPP program were that CCPBH coalition members continue to do violence-prevention work and are currently active in other coalitions, and that more than 30 teen peer counselors have been trained.

Spread Effects

- This project initiated violence-prevention training for summer camp counselors and campers throughout the Boston area, which continues at this time.

- The CCPBH, although no longer in existence, set the stage for the creation of the new Community-Based Volunteer Coalition (COVER), funded by a Federal Maternal and Child Health Grant through the Massachusetts Department of Public Health with the VPP as the lead agency. COVER's goal is to build community capacity through a community-based, multicultural, multidisciplinary, volunteer grassroots effort.

- The first Violence Prevention Awareness Week (VPAW) with the theme "Increase the Peace" was scheduled to take place June 6-12, 1993, throughout the state. A week-long series of events featuring performances and programs was hosted by agencies in their own neighborhoods. In addition, state-based agencies hosted

their events all over Massachusetts and in Boston. The goals of VPAW are to promote increased awareness of the problems of violence and its many faces and causes, to recognize the many efforts already in place dealing with violence, and foster the idea that something can be and is being done. VPP and COVER are spearheading this effort.

- All coalition members saw the need to try to continue the coalition activities. They wrote proposals in order to seek funding to continue the coalition in some form. The coalition was invited to collaborate with the Massachusetts Department of Public Health in their response to an RFA from the Office of Maternal and Child Health. The application requested funding for five years to expand coalition activities in Boston and to replicate the coalition with some adaptation in Lawrence, Massachusetts. The grant was funded, and 1993 is the third year of the grant. The new coalition's focus has expanded beyond training and education and incudes a more diverse membership, representative of all facets of the community.

V. Lessons Learned and Suggestions

The project's coalition and program staff members provided the following experience-based perspectives and suggestions for other projects and OMH.

Lessons Learned

- Evaluators can play important roles in providing technical assistance throughout the life of the project as interactive consultants. Projects should have access to this expertise during the initial design phase.

- "Packaging" the coalition differently by pushing to engage executives of coalition member agencies could garner greater support for institutionalization of a violence prevention curriculum.

- When there are scarce resources, grant-getting may foster competition and, consequently, isolation among groups who want to do the same kind of work.

- The community is usually suspicious of government-sponsored initiatives, so visibility of community leaders becomes an important issue in the development of a successful coalition.

- Any monetary compensation provided to coalition agencies prompts a certain level of support or lends weight to decisionmaking about institutionalization.

Suggestions for Projects

- A comprehensive needs assessment of each coalition agency should be conducted before embarking on coalition intervention in order to establish a level of knowledge from which to work.

- A specific evaluation plan should be outlined at the proposal stage, with pre- and post-testing for project staff and clients.

- Coalition members should have opportunities (i.e., training, workshops, retreats) to interact on a periodic basis, formally and informally, in order to establish relationships with one another.

- Two members from each coalition agency (i.e., one staff person, one manager) should be on the coalition.

- Coalitions should establish linkages with local universities, schools, and other community resources outside the coalition group.

Suggestions for OMH

- Project staff and coalition members should know the amount and scope of technical assistance available from OMH.

- The coalition grant should cover a longer period of time (five years is suggested) in order to properly establish the coalition and institutionalize the intervention.

- Communication should be facilitated between OMH regional minority health consultants and local coalition projects so that projects can take advantage of available OMH resources at the regional level.

The San Diego Samoan Community Exercise for Better Health Project
San Diego, CA

In 1989, OMH made a two-year community health coalition demonstration grant award to the Union of Pan Asian Communities in San Diego, California, to carry out a project to reduce physical underactivity as a risk factor for obesity and cardiovascular disease in the Samoan population of San Diego County.

I. The Context

The Setting

San Diego County occupies the southwestern corner of California adjacent to Mexico and the Pacific Ocean, encompasses 4,231 square miles, and has an estimated population of 2.6 million people. The county contains a considerable Asian and Pacific Islander population including numerous local Cambodian, Chinese, Korean, Japanese, Laotian, Malaysian, Vietnamese, Guamanian, Hawaiian, and Samoan communities.

The Community

The 1980 census counted a total of 2,800 Samoans in San Diego County; a 1987 calculation based on church records and social service agency data placed their number at 3,400. The county's Samoan population is distributed rather widely in the locales of southeast San Diego, Kearny Mesa, National City, Oceanside, and Vista.

California has witnessed significant unemployment, and Samoans have experienced a 55 percent higher unemployment rate than the State as a whole. In general, the Samoan population is poor, with large families (over 50 percent of Samoans are 19 years of age or younger). Almost 30 percent of Samoans live under the poverty level, compared with less than 10 percent for whites. The Samoan population's educational level is relatively low, and 62 percent of persons over the age of 45 have a ninth grade education or less.

San Diego's Samoan population is very cohesive and maintains strong ties with other Samoan communities in northern California, Hawaii, and Samoa. All speak the Samoan language, and many over the age of 45 are monolingual. The Samoan Congregational Church is central to community life; churches have replaced village councils ("fono") as the focus of political and social activities. Consonant with Samoan tradition and values, respectful behavior and deference are accorded to ministers and their families, persons of high family-lineage rank, and all elders.

Health Status

A study of the nutritional patterns of San Diego Samoans conducted in 1984 showed the following rates for chronic disease or related risk factors for adults over 45 years of age:

60 percent had evidenced hypertension, 14.3 had a previous diagnosis of diabetes, 13.3 had experienced a heart attack, and 12.2 had suffered a stroke. The prevalence of massive obesity was 43 percent. Those with high blood pressure had an average weight of 272 pounds for males and 223 pounds for females. Although total kilocaloric intakes were within accepted allowances, the fat proportion of diets was significant. In terms of physical activity, 70 percent of adults had a range of physical exercise that extended from none to minimal. Among Samoans, increased obesity with age is the accepted norm; and physical inactivity among older persons is a concomitant aspect of the tradition of youth demonstrating their respect for their elders by waiting upon them. The study postulated, however, that the stresses of migration, culture change, and the greater relative poverty and physical inactivity experienced in American urban life increased the dangers of these risk factors for San Diego's Samoan population.

II. Project Initiation

Antecedents

As a result of the 1984 study, its PI, two Samoan church ministers, and representatives of local health and social service agencies began to meet periodically to explore ways to address Samoan health issues through community health promotion, which led to the establishment of the Samoan Nutrition Program through the Union of Pan Asian Communities (UPAC). In 1989, this informal committee expanded its membership and formed itself into a coalition to seek funding for a Samoan physical exercise program, and these efforts succeeded in securing the OMH grant award. The grantee organization was UPAC, a nonprofit CBO that currently provides health education and other services through 26 programs to persons of Asian and Pacific Island heritage--speaking 18 different languages and dialects--throughout the San Diego area.

Organization

The coalition's board was composed of organizational representatives and individual members. The former included the ministers of five Samoan churches and representatives of UPAC and of the San Diego Council of Community Clinics (comprised 22 nonprofit community-based clinics). The individual members were the 1984 study PI (a medical anthropologist) and a local physician. The five ministers were recognized leaders in the Samoan community and constituted a majority of the board. The coalition board's mission was to serve as an advisory council and to oversee the progress of the project.

The project's program staff was planned to be composed of a Samoan program director and clerk-typist (full-time, paid), two co-principal investigators (the medical anthropologist and the UPAC director--part-time, at no cost to the project), and a clinician to conduct physical health assessments (the physician coalition member --part-time, at no cost to the project). The program staff possessed in-depth knowledge of the Samoan culture and

language, together with extensive experience in working with the Samoan community. Community volunteers were recruited from the leadership of the churches and included ministers and their wives, deacons and lay preachers, and high-ranking congregation members.

Design

The project's goal was to reduce underactivity as a risk factor among Samoans ages 20 through 55--and older--in San Diego County. The project's objectives were:

- To target 30 percent of the Samoan community for participation in an exercise program, with 50 percent of those targeted to participate in a weekly exercise program;
- To ensure that 50 percent of the program participants would increase their hours of exercise, decrease their weight, and improve their sense of well-being;
- To provide general health information as part of the exercise program;
- To train 50 community volunteer trainers to be exercise coordinators;
- To lend support to the five churches and other coalition organizations for ongoing efforts to improve the health status of their members; and
- To provide a model for replication for other minority groups in San Diego and for Samoan communities elsewhere.

The project's design called for the five Samoan churches to serve as the locus of program activities, including outreach, physical assessments, exercise classes, and health education. The evaluation approach focused on the intervention program per se and encompassed both outcome and process evaluation. These evaluation plans entailed the conduct of individual participant baseline and periodic follow-up assessments through health or social functional status questionnaires, physical status examinations, and health-knowledge tests to measure potential changes that might occur through the intervention program. Also, the monthly review of participant-maintained weekly exercise logs and ongoing communication with the participants were intended to lend insights into the program's process and to provide a mechanism for detecting the potential need for programmatic adjustments.

Central to the project's design was the consideration that it be flexible and appropriate to Samoan cultural values. For example, a component of the project's initial evaluation that which called for one church congregation to serve as a study "control" was abandoned in response to the eagerness of all church congregations to participate in the program rather than serve as a control group as well as in recognition that the close-knit nature

of Samoan society and its widespread communication networks would probably preclude the feasibility of finding a Samoan congregation or community anywhere that could serve as a viable control group. The active involvement of community leaders was viewed as essential, and community input was crucial in shaping the project's orientation, which emphasized the benefits of exercise (rather than the negative aspects of obesity and traditional Samoan foods), underscored the role of community leaders and elders as role models, and drew upon Samoan customs of group competition to promote physical exercise.

III. Project Implementation

The program's activities encompassed the following:

- Outreach and social marketing to attract program participants, including the development and distribution of posters, fillers, and church bulletins, together with announcements from the pulpit and word-of-mouth referrals (reaching approximately 5,000 to 6,000 persons);

- Engagement of community leaders and other interested individuals to serve as volunteer program recruiters, and exercise leaders and in other ancillary capacities to assist program functions;

- Conduct of program participant baseline assessments and initiation of participant-maintained weekly exercise logs, followed by periodic reassessments and exercise log review;

- Development of a module-based health education curriculum for exercise leaders;

- Training of 78 exercise leaders in physical exercise technique, CPR, pulse reading, physical stress detection, and health education;

- Exercise-leader conduct of one-hour exercise sessions for groups of 8-10 persons scheduled for convenience according to age group, occupation, and impairment level, with the last 10 minutes of each session devoted to health education topics; and

- Exercise-leader maintenance of tracking systems for session participants, including recruiting home monitors, monitoring session attendance, and monthly reviewing of participant logs.

The program staff and community volunteers worked closely together in carrying out these activities, and program participants provided continuing input during the process. Attention was given to ensuring the flexibility and cultural appropriateness of all aspects of the implementation phase, including the development and testing of written materials

in the Samoan language and inclusion of Samoans in audiovisual presentations, the methods used for outreach and information dissemination, the recruitment and training of community volunteers, the selection of intervention sites, the adaptation of exercise techniques to fit Samoan modesty taboos, the awarding of program-logo T-shirts and mugs as incentives to draw upon Samoan enjoyment of competition, and adapting evaluation procedures to the sociocultural values and patterns of the Samoan community.

The exercise program attracted strong interest and enthusiastic participation, especially on the part of Samoan elders. However, some difficulties were experienced in the realms of logistics and program attendance. The lack of available transportation to convey the program participants to widely dispersed intervention sites required program staff to provide these services and impeded their ability to carry out scheduled program functions. Also, competing demands on participants' time caused attrition, especially among the 16-24 age group. Although older individuals as a rule participated actively in the exercise classes, many did not appear for periodic health assessment follow-ups. These factors reduced the data available for outcome evaluation.

Two program changes were made. In order to permit adjustment of the implementation strategy if necessary and in light of limited staff, the program was phased into the churches in sequence rather that all at once. Also, the implementation plan was modified to extend outreach to the homebound with no Samoan church affiliation. The program staff's composition and roles changed somewhat during the project's implementation phase; the Samoan clerk-typist assumed the greater responsibilities of program coordinator, and a Samoan outreach worker was added. A paid exercise physiology consultant trained 48 exercise leaders; in turn, these exercise leaders successfully conducted the training of an additional 30, for a total of 78 exercise leaders. The project staff and community volunteers took active part in the program, adopted the behaviors promoted, and experienced the results stated in the project's objectives: increased exercise, reduced weight, and an improved sense of well-being.

The coalition board met formally only twice at the beginning of the project and, in accordance with Samoan custom, these meetings were chaired by the most senior Samoan who happened to be present. The coalition's activities involved the review and approval of program staff selections, strategic plans, policy recommendations, and health education materials. Thereafter, the coalition's five ministers collaborated informally with the program staff in project implementation. Further, most coalition board members took active part in the program and served as valuable role models, and they adopted the behaviors and obtained the results promoted by the project.

Many contributions were made to the project by the coalition board members and their respective organizations. These included recruitment, outreach, and information dissemination efforts, together with donation of church community hall space for program activities (Samoan ministers); sponsorship of the project and office space (UPAC); exercise-leader training in pulse taking and physical stress detection (San Diego Council

of Community Clinics); physical assessments (physician coalition member); program planning, physical assessments, and project evaluation (medical anthropologist coalition member). In addition, at no cost to the project, the local volunteer fire department gave CPR training to the exercise leaders, and a local university statistician assisted in developing the project's evaluation database and tracking system. An anonymous donor gave the churches step-exercise machines, which were extremely popular with the program participants. Further, at considerably reduced cost, local merchants provided exercise mats, 200 pairs of running shoes, and program logo tee-shirts and mugs.

IV. Project Outcomes

The project essentially achieved its objectives. The number of exercise leaders far exceeded the quantity originally planned, and the number of program participants enrolled was on target, although attrition occurred in program attendance. Most participants increased their level of exercise, lost weight, and gained an improved sense of well-being, and the program staff reported having received many telephone calls from participants' regular physicians indicating dramatic improvements in their patients' health conditions that enabled them to reduce or eliminate medication.

The coalition made concerted attempts to find new funding sources to support the project at full strength beyond the 1991 OMH grant termination date, and OMH allowed a six-month no-cost extension of the grant period. These efforts to secure project continuation funding, however, were not successful. As of 1993, the coalition no longer formally existed, although its members and their respective organizations stated that they were prepared to reactivate the coalition if the opportunity arose to secure new funding. In conjunction with the Samoan Nutrition Program, the exercise program continued at varying attenuated levels in the five churches.

The project gained full access to San Diego's Samoan population through the efforts of community leaders, who played a central role in shaping the project's objectives, approach, and programmatic features. During the two-year grant period, the Samoan community incorporated the project into its institutional and social life.

Program participants attested to the benefits they derived from the exercise program and expressed their wish to have it become fully operational again: "It has given us new life; it makes us feel strong." "We got a lot of strength and changed from pain to normal; at first we couldn't walk much, and now we are running." Also, "The program gave us health and was something we looked forward to...we used to sit and home and watch television and not exercise; we need this exercise to carry on." Moreover, Samoans' involvement in the project led to their increased participation in other UPAC health education and social service programs and activities. The project experienced a high attrition rate toward the end of the two-year period. It was highest among the 16-24 age group for several reasons including natural phenomena for this kind of intervention; there

were competing demands for participants' time; the number and types of incentives were inadequate; and transportation was a chronic problem for some participants.

Spread Effects

- The results of the Samoan exercise program were presented in a number of professional meetings and statewide Samoan conferences.

- Information on how to replicate the program was provided in response to requests from the Chinese, Vietnamese, Laotian, and Guamanian communities in San Diego County; Native American tribal reservations in Georgia and Oklahoma; the Samoan communities in Los Angeles, San Francisco, Seattle, and Hawaii; and the Samoan community in American Samoa (on the part of the paramount chief).

- A proposal was written in response to the National Heart, Lung, and Blood Institute's expression of interest in drawing upon the exercise program as a model for conducting a study to include a range of Samoan communities on the U.S. mainland, Hawaii, and American Samoa.

V. Lessons Learned and Suggestions

The project's coalition and program staff members provided the following experience-based perspectives and suggestions for other projects and OMH.

Lessons Learned

- The community-based social systems/reinforcement approach used in this project was effective in initiating and sustaining behavioral change. This approach used culturally meaningful systems of rewards for achieving goals, relied on cultural values of the community and educating participants about applying those values to current health information, used community leaders and volunteers as agents of change, and promoted behavior change without any perceived penalties. Moreover, this approach should be replicable for other community-based projects regardless of the specific cultural characteristics or health problems concerned.

- Projects should perform a preliminary assessment to identify potential factors (e.g., transportation difficulties) that will have to be accommodated in program design and implementation.

- Over time, the inclination of program participants to actively engage in an exercise program will cyclically wax and wane, and therefore a strong incentive/reward system should be initiated at the outset and maintained to encourage full participation.

- The use of individual activity logs maintained by program participants enhances their sense of personal responsibility and motivates them to sustain new behaviors.

Suggestions for OMH

- The grant period should be extended to at least to three years to allow sufficient time for project development, implementation, and evaluation, as well as to permit enough time to secure new sources of funding to continue program activities.

- More attention should be given to grantee's capacity-building skills, e.g., proposal writing, project management, and evaluation.

- The OMH Resource Center should be publicized more. It should establish an on-line database accessible to applicants and grantees.

- The need to find project continuation funding should be emphasized at the beginning of the application process.

- Joint project funding by Federal agencies that have similar goals and objectives should be considered.

- More technical assistance should be provided.

Black Infant Mortality in Fulton and Terrell Counties, Georgia
Fulton and Terrell Counties, GA

In 1989, OMH made a two-year community health coalition demonstration grant award to CONTINUUM, an established statewide coalition of organizations concerned with maternal and child health, to carry out the Black Infant Mortality Project in urban Fulton County and rural Terrell County, Georgia.

I. The Context

The Setting

This is one of the 2 two-site projects among the 26 projects in the study sample. This project's goal was to reduce African American infant mortality rates in designated portions of urban Fulton County and in rural Terrell Counties, Georgia.

The Communities

Fulton County represents the urban component of the project and encompasses the city of Atlanta. The 1987 pregnancy rate for teens, ages 10-19, was 64.4 per 1,000 females, compared with Georgia's overall rate of 47.6. Of the 22 health centers in Fulton County, six are located in areas that accounted for over half of all teen pregnancies, and approximately 33 percent of people in these areas were at or below the poverty level (1980).

Terrell County is a rural county in southwest Georgia with a total population of 12,902. The birth rate for African Americans ages 10-14 is 8.1 live births per 1,000 females, for ages 15-17 it is 47.1/1,000, and for ages 18-19 it is 87.2/1,000. The post-neonatal death rate for African Americans is almost twice that of the State as a whole. Resource limitations in Terrell County included poor transportation, few homes with telephones, and no hospital for deliveries in the county.

Health Status

The southeastern United States continues to exceed the national averages in infant mortality, teenage pregnancy, low birth weight, and poor access to prenatal and postnatal health care. A major contributor to the high infant-mortality rate in Georgia is the high rate of teenage pregnancy. For the five-year period 1980-84, the white infant mortality rate was 10.14 per 1,000 live births, while the African American rate was 19.81 per 1,000 live births. During this period, there were 1,938 excess deaths among African American infants.

II. Project Initiation

Antecedents

The lead agency of the coalition originated in the 1960's as part of B'nai Brith Women's Council, a group of Jewish women who worked as volunteers to health care or health-related organizations. The coalition consisted of an alliance of volunteers and health care professionals who advocated for change in health care delivery and added an emphasis on minority health.

By the late 1980's the membership of organizations working cooperatively on these issues stretched across the State and came to be known as CONTINUUM. This statewide coalition of organizations received a Maternal and Child Health (MCH) /SPRANS DHHS grant in 1987. This grant subsidized the coalition's activities in the areas of minority infant mortality, prenatal care, and teen pregnancy. The OMH funding, received after the MCH/SPRANS DHHS grant, implemented models of community outreach and service delivery already developed by the coalition. It was the CONTINUUM coalition that received OMH funding.

Organization

CONTINUUM is a statewide organization composed of service providers and volunteer organizations. Originally, there were plans to organize a task force (subcoalition) of concerned individuals and organizations at each project site. These task forces would interact with the project staff and volunteers. They would work locally to remove barriers to care, promote preventive health care, focus the community on its major needs, and generate resources, new policies, and practices to address them.

The project staff consisted of a project director based in Atlanta, a deputy project director responsible for Terrell County who was a native of and lived in the city of Albany (in the adjacent county to the south of Terrell), and two clerical support staff. Consultants were used for specific tasks, (e.g., project evaluation). The project trained Teens In Action (TIA), Resource Mothers, peer counselors, and task force volunteers.

Design

Prior to OMH funding, CONTINUUM was focusing on minority health with its Minority Connection Project; this was the model for the African American Infant Mortality Project. The project drew on the strengths of one of the most influential institutions in the African American community by being church-based. The project used a two-pronged, church-based outreach strategy for their TIA and Resource Mothers programs. Both efforts were designed for teenagers to increase self-esteem, identify career objectives, develop decisionmaking skills, address issues of peer pressure and sexuality, and increase the access of pregnant teenagers to prenatal care.

Although infant mortality can be lowered by providing excellent prenatal care to teens, the project felt that this approach was less cost-effective than reducing the teenage pregnancy rate. Access to contraceptive services is a necessary, though not sufficient, component of such a program. The health departments in both target areas provided contraceptive services for teens, but these were underutilized. Little sex education was available to teens in the targeted areas, nor were there venues in which to discuss values and attitudes. Specific information about the above services and sex education thus became important components of the project.

The goal of the project was to reduce African American infant mortality rates in designated portions of urban Fulton County and in rural Terrell County, GA. The project objectives were:

- To develop and implement a comprehensive program of teenage pregnancy prevention in six Atlanta neighborhoods and in Terrell County,

- To increase the accessibility and availability of prenatal care to pregnant African American teenagers in six Atlanta neighborhoods and in Terrell County, and

- To increase the accessibility and availability of postnatal health care and other support services for African American teenage mothers and their infants in six Atlanta neighborhoods and in Terrell County.

III. Project Implementation

The project director, assistant project director, and the area liaison persons coordinated and directed the support of the local coalition members. A task force was formed in each county to work locally to remove barriers to care discovered by the staff or volunteers, promote preventive health care, focus the community on its major needs, and generate resources, new policies, and practices to address them. The Fulton County task force had 7 active members, and the Terrell County task force had ten.

A task force (subcoalition) was organized for each project site to direct and oversee project activities. A major portion of time and effort were devoted to networking, developing community awareness and relationships, and organizational development.

The four intervention components of the project included

- TIA: peer counseling to teach about sexuality and alternatives to teen pregnancy;

- Resource Mothers: support and guidance to pregnant teens and teenage mothers;

- Prenatal Outreach to Women Education and Referral (POWER): hotline for pregnant women and young mothers; and

- Parent-Infant Intervention Project (PIIP): a health-department-based program of prenatal and postnatal parenting education.

Creative presentations utilizing humor, role-playing, and training aids were used in training programs. A small cultural component on African American history, arts, and literature was integrated into the training sessions as well. T-shirts, jackets, and other TIA identifiers for the youths served as significant motivators and bonding mechanisms used to build self-esteem and to bond the TIA's to the program and to one another. By the end of the project, teen leaders had become the primary program recruiters.

Volunteers for the project included adult advisors, college students, Resource Mothers, and TIA peer counselors. The adult advisors consisted of 14 professionals, including doctors, nurses, faculty members, and heads of community-based organizations, who volunteered to provide a wide range of technical assistance to the project, while the latter groups were drawn from the target population. Layette gifts were used as incentives for pregnant teens to start their prenatal care during the first and second trimester. This appears to have been a project innovation to increase compliance among clients.

The evaluation plan was to utilize formative and summative assessments to serve as suggestions for improving the implementation approach. Specifically, the evaluation was to use the following information: (1) review of project proposal; (2) review of project files and monthly reports; (3) personal interviews with the former and present project directors; (4) survey of Resource Mothers; (5) survey of TIA's; (6) survey of task force members; and 7) visits to Fulton and Terrell County project sites. Because limited resources were allocated for the evaluation effort, the evaluation was organized around personal interviews with the project administrators, review of project documentation, and a series of year-end questionnaires administered to program participants.

The resignation of two project directors within eight months in the first year resulted in a longer than anticipated start-up time. Poor communication between and incompatible management styles of the project director(s) and the PI (from CONTINUUM) appear to have adversely affected project administration, implementation, and outcomes, particularly in Fulton County. It appeared that the Fulton County task force did not receive the support it needed to organize effectively. It did not develop the necessary cohesiveness because of the scale of service provision usually needed in large cities and the difficulty of getting organizations to identify with small neighborhoods. Coalition members experienced schedule conflicts and personnel turnover. Nevertheless, four churches in Fulton County accepted the program and were able to implement the two main project interventions (TIA and Resource Mothers), and a comprehensive program of teen pregnancy prevention was realized in five of the original six targeted areas in Fulton County.

Only the Terrell County task force became fully functional. Terrell County received more attention from the project director than anticipated during the organizational phase of the

project because of its rural location and a complex combination of organizational, logistical, and race-related incidents. The efforts of a highly motivated, resourceful, and dedicated deputy project director and task force member in Terrell County made it possible for the project to accomplish most of the project's objectives in the face of tremendous racial, bureaucratic, and social barriers.

Efforts to find post-OMH funding were initiated too late to continue the project. However, two of the original Fulton County churches are continuing a low level of project activities. The deputy project director continued to provide services to the Terrell County pregnant teens on a voluntary basis through their delivery (up to six months after OMH funding ended). These teens continue to communicate with the deputy project director and still sometimes request assistance. She considers them "her girls."

IV. Project Outcomes

Since OMH funding has ended, the coalition persists with many of the activities now funded by State and foundation monies. The composition of the membership has changed, however. The former director of CONTINUUM formed a separate organization called the Maternal and Child Health Institute, and CONTINUUM is now headed by an African American woman. The coalition's programs have been reduced to a single service, the telephone hotline. The hotline was regarded by some informants as the "white project" while the Resource Mother and peer-group counseling projects were viewed as the "black projects." In the new coalition, the rural component of the project does not seem to be included; and the coalition's focus and outreach to minority communities has weakened.

Outcomes from this project that addressed the target community and local health care resources were as follows:

- An adjoining county hospital agreed to provide prenatal care to Terrell County teens participating in the project.

- The project assisted in networking with existing resources and initiating a program of community outreach.

- A total of 53 TIA's completed the training and received certificates from CONTINUUM, and an additional 17 TIA's were certified as peer leaders in Terrell County.

- Twenty-seven Resource Mothers were trained for the project in Fulton County. Three community churches in the target areas were motivated to start their own RM program and trained an additional 14 Resource Mothers. Four Resource Mothers were trained in Terrell County and functioned effectively until the last quarter of the project. Illness and job responsibilities prevented them from continuing their commitment.

• The POWER hotline received approximately 30 telephone calls a month from Fulton County and 15 calls over the course of the project in Terrell County. Although some teens have used the services of the hotline, there is a need to market the availability of this resource. The hotline's computerized data collection system does not allow for retrieval of information by census tract in Fulton County, so any change in the number of calls from those target areas cannot be easily measured.

• An incentive program to motivate pregnant teens to seek early and continuous prenatal care was implemented. The total caseload for the program was 82 in Fulton County and 76 in Terrell County, respectively. Twenty-three of the mothers were 12 years old or younger. A total of 23 babies were taken into the program to be followed at birth in Fulton County and 17 in Terrell County. They were followed through their first year of birthdays. There were no infant deaths in the group of infants followed.

• The Terrell County Health Department has reported an increase in the number of teenagers who seek health care for themselves and their babies.

• The Health Department believes that accurate evaluation of the project's impact can only be conclusive after a five-year period. Therefore, no attempt to measure impact has been made.

Spread Effects

- Charity organizations and private industry are now becoming more involved in helping to meet needs at the grassroots level.

- Nonproject clients at a Terrell County hospital are benefiting from policy changes that were initiated by the project.

- At the conclusion of the project, the core of the advisory committee in rural Terrell County had acquired knowledge in establishing linkages with organizations outside of the county.

- The project was able to attract supplemental funding to enable it to implement project activities.

- The project has significantly improved access to health care for pregnant teenagers in Terrell County.

- A male member of the Terrell County task force has been elected mayor of Dawson, the county seat and largest town in Terrell County.

- Project activities have continued to some degree in the original Fulton County churches despite a lack of post-OMH funding (e.g., TIA's and Resource Mothers are still active).

- Terrell County teens involved in the project continue to communicate with the deputy project director and sometimes request her assistance.

V. Lessons Learned and Suggestions

The project's coalition and program staff members provided the following experience-based perspectives and suggestions for other projects and OMH.

Lessons Learned

- Both the Resource Mothers and TIA linkage with the project proved to be effective. However, the TIA was thought to have an advantage over Resource Mothers in certain situations. For example, some teens indicated that it was easier to confer with and confide in a peer counselor.

- The project should have provided orientation or training for coalition members (e.g., their roles, project design) to ensure that they have the necessary skills to carry out their function and to create a feeling of ownership.

- The project management and budget should have been decentralized to allow a reasonable level of decision-making among principals at each intervention site.

- A greater effort is needed to involve the babies' fathers of pregnant teens.

Suggestions for Projects

- Community diagnosis and network analysis should be conducted and used for project design and the formulation of implementation strategies.

- Necessary policy changes must precede and facilitate new project initiatives. For example, Terrell County pregnant teens did not have ready access to health care (some had to travel to Albany, Georgia, to receive prenatal care and deliver their babies), some were refused treatment by physicians in Terrell County, and in some cases Terrell County government Medicaid benefits were illegally withheld from them.

Suggestions for OMH

- A project should not seek to have OMH manage its personnel, and OMH should decline to become involved in personnel matters.

- A film/video library on health topics and issues related to minority communities should be established at the OMH Resource Center, with a mechanism for short-term rental if these resources.

- More hands-on training should be provided for project staff.

- Coalitions should be minority-centered before funding is provided.

- In order to ensure local ownership of the project and obtain valuable impact data, projects should be funded for a minimum of three to five years.

Community Partnership for the Prevention of Alcohol and Drug Problems Among Perth Amboy Latino Youth
Perth Amboy, NJ

The University of Medicine and Dentistry of New Jersey (UMDNJ) - Robert Wood Johnson (RWJ) Medical School (formally known as Rutgers Medical School), in partnership with La Cooperativa, a local community coalition in Perth Amboy, received an OMH grant in 1989 to strengthen and enhance their pre-existing collective efforts. The focus of their collaboration was the prevention of alcohol and other drug problems among the city's Latino youth.

I. The Context

The Setting

The population of Perth Amboy is 41,967. The Latino residents of Perth Amboy constitute 55.5 percent of the city's population (1990 census). The ethnic diversity of Perth Amboy's Latino community is fairly reflective of the Latino population living in the northeast United States: approximately 55 percent are Puerto Rican, 20 percent are Dominican, 15 percent are Central and South American (primarily from Colombia, Ecuador, and El Salvador), and 10 percent are Cuban. Most of these figures are based on estimates, in since several of the above groups are undocumented and, therefore, undercounted. With a median age of 25, Latinos make up 85 percent of Perth Amboy's school population.

According to various social indicators, Perth Amboy has a very high rate of problems compared with other cities in Middlesex County and New Jersey in general. In 1980, the city had the lowest per capita income ($6,000) in the county. Twenty-nine percent of Latinos were below the poverty level, compared with 18.8 percent of African Americans and 15.5 percent of whites. Twenty-one percent of Latinos received public assistance, compared with 11.5 percent for all other ethnic groups. In 1986, Perth Amboy suffered from the highest suicide rate and the second highest rate of violent crime in the county. The fertility rate of young females 10-19 years of age was almost four times the county rate. Within the target area, the unemployment rate was 20 percent, the school drop-out rate was 47.5 percent, and 25 percent of the households were headed by single females under the age of 18. Half of the children below the age of 19 lived in poverty.

The Community

Latinos are concentrated in two Perth Amboy neighborhoods defined by the U.S. census Bureau as Neighborhoods A and B. In 1980, Latinos constituted 65.5 percent and 65.8 percent respectively of Neighborhoods A and B. Neighborhood A was the project's intervention target area. In Neighborhood A, 42.5 percent of the population was 19 years of age or younger.

Within the target area, the project had primary and secondary target populations. The high-risk Latino youth, defined as young people ages 10 through 18, were the primary target; and all of the project's objectives were directed toward the prevention of alcohol and drug problems among this population group. They were the intended recipients of the project's services. The categories of at-risk youth included children of substance abusers; victims of abuse (physical, sexual, psychological); chronic failures at school; school drop-outs; pregnant, economically disadvantaged young females; those who committed violent or delinquent acts; those with mental health problems; and attempted suicides.

The secondary target population, defined as groups that influence the well-being of these young people, were their parents, the workers in the agencies that serve them (teachers, recreation workers, health and human service personnel), and community leaders (priests, leaders of social clubs, elected and appointed officials, and others). While they were not intended to be the key recipients of program services, these persons were targeted to be reached and involved in efforts that would increase their awareness of alcohol and drug-related problems and their participation in community activities to prevent the occurrence of these problems.

Health Status

There is strong evidence that Latino men exceed the general population in prevalence of alcoholism and drug abuse. The stresses of acculturation, induced by cultural changes, disruption of families, language barriers, and discrimination, lead to heavy drinking and alcoholism. Nine percent of Latino men report that their drinking has had harmful effects on home life, whereas only 6 percent of African American men and 4 percent of white men report this problem. These findings suggest that a substantial number of Latino youth are living in families with alcohol and drug problems. As children of alcoholics or drug abusers, they face many risks, because family drinking behavior appears to strongly influence the drinking of young Latinos. While few adult Latinas are found to drink heavily, the highest rate of problems is found among young women 19-29 years old. This finding suggests the need for alcohol- and substance-abuse prevention among adolescent Latinos and prevention efforts against other issues such as delinquency, school failure, and adolescent pregnancy.

II. Project Initiation

Antecedents

In the fall of 1986, a group of Latinos who live and/or work in Perth Amboy came together in La Asuncion Church to discuss ways to cooperate in addressing the health and many other problems faced by young people and their families. Of special concern was the prevention of alcohol and other drug-related problems among Latino young people. This meeting was the genesis of the formation of La Cooperativa, a collective of concerned

individuals that has since become the advisory body of the Community Partnership for Youth Project. The formation of La Cooperativa represents the first of many undertakings that the community and other institutions would initiate together.

Organization

The original coalition consisted of 12 cooperating agencies and six individuals. The health agencies included four community-based organizations, three church organizations, two nongovernment organizations, and three other organizations. All members were Latinos. An active and key member of the coalition was the UMDNJ Medical School, which worked shoulder to shoulder with the group in the provision of resources and technical support. The pastor of La Asuncion Church was a natural community leader and was very active and a strong advocate for the community and the project. La Asuncion Church was the site of coalition meetings and the operation base of project staff. The coalition met bimonthly at first and then every three months thereafter. UMDNJ-RWJ Medical School served as the fiscal conduit and collaborator in all aspects of the project.

La Cooperativa, which evolved from a community awareness process, served as the vehicle through which the model for prevention programs was developed. As a knowledgeable body of community representatives, the coalition members functioned as the advisory board and community coordinating body for the project. The mission of the coalition was to develop strategies and implement processes that resulted in leadership development, community empowerment, and social change within the Latino community of Perth Amboy. Its role was to support the program by facilitating staff access to networks in the community, trouble-shooting, and enabling access to resources (e.g., space for programs, equipment and supplies).

At the beginning of the project, the staff consisted of one full-time and three part-time persons (three Puerto Rican and one Dominican.) By the end of the project, staff had increased to five full-time and five part-time. The project staff formed the Community Action Team--each with a specific role and function. The team developed a pool of volunteers composed of youth, parents, and interested adults. The volunteers played a key role in the planning, production, and dissemination of community awareness materials, and they helped plan and participate in a communitywide forum in the second year.

Design

The main goal of this project was to develop and evaluate a community-based model for developing and delivering programs to reduce the risk of alcohol and other drug problems among high-risk, urban Latino youth in Perth Amboy, New Jersey.

The project had a primary target population of high-risk Latino youth between the ages of 10 and 17 and a secondary target of parents, workers in agencies that served the youth, and community leaders. The major interventions included in-service workshops for agency staff, professionals, etc.; raising community awareness through town meetings, a bimonthly newsletter, and dissemination of educational materials; fostering the development of prevention programs by community institutions (e.g., churches, schools, recreation facilities, and housing projects); and encouraging interagency cooperation.

The program objectives were:

- To increase awareness concerning alcohol and drug-related problems in the community;

- To increase awareness concerning the community's role in reducing the risk of such problems among young people;

- To develop a community alliance dedicated to reducing the risk of alcohol and drug problems among its youth;

- To increase alcohol and drug abuse training and the integration between existing programs that have the potential for reducing the risk of alcohol and drug problems among young people;

- To improve the dissemination of prevention programs that have the potential for reducing the risk of alcohol and drug problems among young people;

- To improve the utilization of prevention programs that have the potential for reducing the risk of alcohol and drug problems among young people; and

- To reduce the impact of social, psychological, or behavioral factors that are associated with increased risk of alcohol and other drug problems among children and adolescents.

To achieve the above objectives, the project conducted outreach at many locations where the target population was most likely to be found (e.g., in streets, parks, laundromats, churches and schools) and door to door.

III. Project Implementation

The program had a number of components: youth empowerment, parent support group, government officials involvement, quarterly newsletter for professionals and service providers, providers conference, community forum, mass media liaison, providers coalition, tutoring, peer tutoring book, school personnel in-service training, outreach, madrina/padrino program, summer program, leadership development, cultural and

recreational activities, adult health promotion, and sexuality education. Some components were added as needs were identified during the course of the project, e.g., the Community Forum in which community members and city officials discussed problems that confront Perth Amboy residents, the Providers Coalition to collectively work on common issues, and sexuality training for program staff and sexuality workshops for parents and youth.

Participants in all activities were recruited through outreach at the schools, housing projects, the church, laundromats, grocery stores, and other locations where the target population is known to gather. Most adult participants were parents of children enrolled in various program activities.

A number of strategies were used to ensure the cultural appropriateness of the various program activities, such as making sure the staffing pattern reflected the target population, providing bilingual staff and communication, engaging participants in cultural celebrations, and tailoring activities to be relevant to the culture. In addition, quarterly cultural events were organized.

An average of six to eight members attended coalition meetings regularly. The coalition participated in staffing decisions, provided feedback on program ideas, participated in committee work, and handled advocacy issues. Individual members or member organizations provided on-going professional consultation, space for tutoring and program activities, and mailing lists and audiovisual equipment.

The project director/PI was responsible for the project evaluation. The evaluation had both an outcome and a process component. The household surveys for the outcome evaluation were conducted by the Eagleton Institute of Public Affairs at Rutgers University.

A multifaceted evaluation approach was developed to facilitate and assess the achievements of the program's objectives. Evaluation procedures included face-to-face interviews with formal and informal community leaders; systematic documentation of the nature, extent, and use of community programs; telephone interview surveys with probability samples of Latino parents and adolescents living in the intervention community (Perth Amboy) and in a comparison community (Jersey City) to establish a baseline for the assessment of progress toward objectives; and in-depth qualitative interviews in panels of selected families, in both intervention and comparison communities, to gain a better understanding of the social dynamics of risk factors faced by families.

The community survey data, in the intervention and comparison communities, are intended to provide a baseline for the assessment of change after the Community Partnership program has been in effect. The data derived from qualitative interviewing are intended to increase the understanding of the social and familial dynamics of change with respect to risk factors for alcohol and drug abuse among Latino youth. A recent

increase in evaluation funds awarded by CSAP will permit the completion of three rounds of surveys and quantitative interviews. The results will enable the coalition/project team to document a model of community organizations for the prevention of alcohol and other drug problems among Latino youth. It is anticipated that this model may be replicated in other similar communities.

Funding from the OMH grant enabled the evaluation process to be implemented to obtain baseline data for youth and adults, as well as the two-year completion of the process evaluation. Final outcome data will be obtained at the completion of the CSAP five-year grant.

IV. Project Outcomes

The UMDNJ-RWJ Medical School was, and remains, the lead agency for the Perth Amboy Partnership for Youth. As grantee organization, the state medical school has lent certain advantages to the coalition: (1) as a non-local entity, it has provided neutral ground for cooperation; (2) it has brought visible prestige to the effort; and (3) it has served as a resource for in-kind contributions, especially in regard to evaluation research and grantsmanship. Moreover, the medical school's administration has not interfered in the project or used it to pursue potentially conflicting agendas in the community. This is in great part due to the role that the Latina PI, who is a faculty member, has played as gatekeeper. The project's Latina director, and Latino staff (full-time and part-time) have demonstrated a high degree of cultural competence, commitment, and resourcefulness.

The project's community involvement and education goals and objectives have been rather generic and comprehensive, rather than specific and disease-oriented. This orientation places emphasis on enabling the community to identify its problems and to determine how best to meet them, and it gives flexibility for addressing changing community needs and including new components in its approach.

The coalition's membership includes highly respected Latino community members with considerable political savvy and an action orientation. The coalition continues to function as the advisory committee to the Perth Amboy Partnership for Youth, has maintained much of its original membership and expanded to include new members, and continues to meet monthly.

The project's staff have clearly delineated job descriptions. They demonstrate personal dedication to effectively addressing community concerns. Volunteers--five interns and two medical students--contributed greatly to the program resources and activities. The interns reported to the program director.

The project's overall approach and specific interventions are very respectful of Latino cultural values and institutions. The empowerment strategy is the common thread that runs through all activities. The project is open to all people of color, and a number of

African American students participate in its programs. More effort could be made to identify and reach out to at-risk Latino youth--planning for such an effort is now under way by the project.

Access to the privately owned Raritan Bay Community Health Center for the Perth Amboy Latino community is limited and represents the only local primary health care facility. The coalition planning has begun to address this issue through consumer representation in the governing board and the establishment of a federally funded community health center.

An important outcome of the OMH funding was that it served as the springboard for obtaining additional funding from CSAP. During the second year of funding from OMH (1990), a five-year grant was obtained from the CSAP High Risk Youth Grants Program. Also, numerous smaller foundation grants have enabled the program to expand to conduct sexuality health education with parents and youth. These grant sources include the Robert Wood Johnson Foundation and Rutgers Community Health Foundation.

Spread Effects

- The project has expanded its programs and participants as needs have been identified, e.g., substance abuse prevention now includes tobacco; human sexuality is now addressed, with attention to prevention of pregnancy and disease; parents now play a number of roles (e.g., godparent program, parent support group, parent-peer sex education, volunteers); and cultural sensitivity training has been provided in the wider public school system, as well as in four Roman Catholic dioceses.

- A positive impact has been made on Latino youth involved in the project. Participants have strengthened and/or learned a number of skills: how to conduct research, how to think critically, how to use research for social change, and how to make public presentations. They have been exposed to career options, and their increased confidence and skills enabled them to aspire to and pursue a university education.

- The increased political involvement and empowerment of the Latino community is demonstrated by student presentations and petitions, and by Latinos gaining elective and appointive office (e.g., a Latino was elected mayor in the last election, and a project staff member ran for a seat on the Board of Education; he lost the election by a close margin but was appointed by the Mayor to the Housing Commission).

- The state medical school has implemented a focus on community-based prevention and has received recognition at the State and national levels from the Surgeon General and the National Task Force on Health Care Reform. The

partnership with the community is demonstrating how a major medical institution can work closely and positively with a community.

V. Lessons Learned and Suggestions

The project's coalition and program staff members provided the following experience-based perspectives and suggestions for other projects and OMH.

Lessons Learned

- The achievement of objectives in a youth-focused program depends on parental involvement.

- Services must be perceived by the client as addressing current felt needs.

- There is a risk of falling into a service-delivery, missionary-type, dependency-creating approach. To truly enable and empower the community, this temptation must be avoided. The question the project director asks staff during each project review sessions is "Are you doing for, doing with, or allowing people to do for themselves?" This has become the project's theme.

- If existing service-delivery providers and agencies are approached in a straightforward manner for the purpose of meeting and sharing viewpoints, they will respond positively in a majority of cases. That is, perceived potential barriers should be tested, and efforts should be made to be inclusive.

Suggestions for OMH

- Consideration should be given to increasing the number of years and amount of funding for the Minority Community Health Coalition Demonstration Program in the future.

- Funding should be continued for those promising programs that have shown a long-lasting positive impact in their communities.

- Annual meetings should be held with grantees in order to allow for the exchange of information and ideas and for networking.

IV. HYPOTHESIS DEVELOPMENT AND MULTIPLE-CASE-STUDY ANALYSIS

The 26 projects funded through the OMH Minority Community Health Coalition Demonstration Grant Program between 1986 and 1989 attempted to positively modify such behaviors as smoking, condom use, diet, and exercise, which are extremely difficult to change, regardless of the size and scope of the interventions employed. Further, the projects under review tried to affect populations that are difficult to reach and that have the poorest health indicators in the United States within two-year grant periods with funding at a level of only $200,000. Where national health campaigns and other more specialized, targeted, and well-financed interventions have failed, these projects sought to make inroads on intractable health problems among the most medically underserved populations and with limited time and money. In short, the projects attempted to do more with less, in fact, much more with much less.

Under these circumstances, it would not be realistic to expect the projects' outcomes to reflect a high degree of community change in behavior, much less in health status. Indeed, the accomplishments of forming coalitions and continuing them in original or modified form might in itself be viewed as an important outcome. In light of the foregoing, and because these projects represented innovative demonstration efforts shaped to the cultures and health problems of specific minority communities, there is no single standard of relative success against which all of the projects can be measured. This view made it more appropriate to focus on the outcomes achieved by individual projects in terms of the objectives they set for themselves as well as on the degree to which project coalitions and intervention programs continued after the end of OMH funding. Therefore the Study Team did not make comparisons between projects, but rather sought to determine which characteristics are associated with which positive outcomes across projects. In this context there were no failures--only degrees of accomplishment of stated objectives.

The Study Team's review of secondary (documentary) data on the 26 projects yielded information on such factors as types of grantee organization (Figure 1), ethnicity of target populations (Figure 2), health problems addressed (Figure 3), evaluation efforts, and continuation of coalitions and intervention programs. Further, the Study Team's careful analysis of primary data gathered through site visits to 13 of the 26 projects lent insights into more subtle and intangible elements, such as a project's contribution to a community's sense of empowerment and the spread effects of a project beyond its original target population and health problem focus.

A. Summary Analysis of the 26 Projects

The type lead agency for project grantees varied: state, county, or local public health department or other government agency (30 percent); university or medical institution (27 percent); national, state, or regional nonprofit entity (12 percent); and community health center or other community-based organization (CBO) (31 percent).

Eight of the 26 projects (31 percent) had CBO's as lead agencies, the same percentage as among the site-visited projects. All four of the site-visit CBO's had a medium level of objective achievement. Spread effects were highest among this category of lead agency. CBO's appeared to be more representative of the target community than any other type of lead agency, except in cases where coalition membership included individuals.

Most projects tended to have a rather concentrated focus in terms of both targeted populations and health problem. The majority of the projects (62 percent) were characterized by a relatively low level of cultural complexity[2]: one ethnic group and one health problem. Sixty-five percent of the projects did not select a problem that involved social stigma (e.g., teen pregnancy, substance abuse, violence).

All of the 26 projects attempted some form of process evaluation. Fifteen projects (58 percent) provided documentation of evaluation plans. However, only 3 of the 26 projects actually conducted and provided supporting data for project impact on target populations. The low level of evaluation data was traceable to a variety of reasons: nonmeasurable project objectives, the lack of evaluation skills among project staff, unavailability of OMH technical assistance on evaluation design and implementation, late attention to the evaluation component, project timeframe too short (two years) to demonstrate impact, and inadequate allocation of project funds for evaluation purposes.

It is reasonable to surmise from the data that OMH funding significantly stimulated the growth of the kinds of coalitions that were intended. Seventy-three percent of the coalitions did not exist prior to receiving OMH funding. The projects and coalition's funded by OMH appear to be long lasting. An overwhelming majority (81 percent) continued after OMH funding ceased, and 18 coalitions (69 percent) were still operational in 1993 in the same or modified form. Some of the continuing projects reported success in obtaining funding from a variety of public and private sources on a wide range of funding levels ($50,000 to $2.3 million).

B. Hypothesis Development

Approach

Soon after completing the first few project site visits, the Study Team began to assess the nature of the outcomes that it was finding and to determine the project characteristics that, in combination, seemed most likely to be associated with positive outcomes. In the course of synthesizing and analyzing site-visit findings, the Study Team tentatively identified 10 outcomes (dependent variables) and 44 characteristics (independent variables). The Study Team then closely examined and refined these. The resulting five

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[2] This refers to the need to target more than one ethnic group or to deal with issues such as immigration or undocumented workers, more than one language, and varied family structure.

positive outcomes identified (dependent variables) were achievement of (a) project objectives; (b) coalition continuation; (c) intervention program continuation; (d) community empowerment[3]; and (e) spread effects. The resulting 35 project characteristics (independent variables) included factors relating to the overall project (e.g., target population selection, target health problem identification, evaluation); the project coalition (e.g., community leader involvement, organizational composition, roles and functions); and the intervention program (e.g., project staff, roles and functions, ethnicity, community volunteer participation, community input, cultural appropriateness, flexibility).

The Study Team then generated the following list of 35 hypotheses that linked certain outcomes to specific characteristics. These outcomes were chosen for the specific purpose of formulating testable hypotheses, and they almost certainly do not represent all that might be identified. It should be noted that project outcomes and project characteristics are interrelated in complex ways.

Hypotheses

1. To the extent that the project involves cultural complexity, the greater the difficulty the project will have in achieving

    a. project objectives
    d. community empowerment

2. If the targeted health problem is associated with social stigma, it is more difficult to achieve

    a. project objectives
    c. continuation of program

3. If the coalition exists prior to efforts to secure OMH funding, it is more likely that project will achieve

    a. project objectives
    b. continuation of coalition
    c. continuation of program

[Size in terms of numbers of coalition members (organizational or individual) per se is not significant relative to project outcomes. However, coalition

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[3] Empowerment is indicated by the degree to which communities shape and demonstrate a sense of ownership of a project and take responsibility for addressing and having impact on local health and related issues.

composition is important to three functional areas:

- **securing grant funds;**
- **securing cooperation of critical gate keepers;**
- **carrying out specific tasks.**

4. If the project grantee organization is a CBO, the greater the chances of achieving

   d. community empowerment

5. The degree to which one or more CBO's are active on the coalition,[4] the greater the chance of achieving

   d. community empowerment

6. The more the coalition membership reflects the racial/ethnic composition of the target community, the greater the chance that the project will achieve

   d. community empowerment

7. If the coalition includes natural community leaders,[5] it is more likely to achieve

   d. community empowerment

8. To the extent that program staff reflects the racial/ethnic composition of the target community, the greater the chance that the project will achieve

   d. community empowerment

9. To the extent that program staff reflects the gender composition of the target population, the greater the chance that the project will achieve

   d. community empowerment

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[4] For our purposes, this refers to one standard and representative point in time: the beginning of the second project year.

[5] A representative of the target community who is formally or informally recognized by many or most of the project's targeted group as a leader who is in some way connected with the objectives of the project. He or she exerts influence and operates on the basis of popular consensus, local legitimacy, and trust.

10. To the extent that the program uses outside consultants to supplement or complement program staff, the greater the chance that the project will achieve

    a. project objectives
    b. continuation of coalition
    c. continuation of program

11. If paid community outreach workers live in the target community, share the culture and speak the language of the target community, and are directly or indirectly affected by the targeted health problem, the greater the chances that the project will achieve

    a. project objectives
    b. continuation of coalition
    c. continuation of program
    d. community empowerment
    e. spread effects

12. To the extent that the program is able to attract and retain community volunteers[6], the greater the chances that the project will achieve

    b. continuation of coalition
    c. continuation of program
    d. community empowerment
    e. spread effects

13. If baseline data is empirically gathered and analyzed within the first six to nine months of the project, the greater the likelihood of achieving

    a. project objectives

14. If formative information is empirically gathered and analyzed within the first six to nine months of the project, the greater the likelihood of achieving

    a. project objectives

15. If a process evaluation is conducted, the greater the likelihood of achieving
    a. project objectives
    b. continuation of coalition
    c. continuation of program

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[6] Attraction and retention of volunteers may be operationally defined as attracting three or more volunteers and retaining them for at least 50 percent of the life of the project.

16. If an outcome evaluation is conducted, there is a greater likelihood of achieving

    a. project objectives

17. To the extent that suitable[7] steps are taken to insure cultural appropriateness when evaluating project process, the greater the likelihood of achieving

    a. project objectives
    b. continuation of coalition
    d. community empowerment
    e. spread effects

18. To the extent that formative and/or baseline information is empirically gathered, analyzed and used in project (re)design and implementation, the greater the likelihood of achieving

    a. project objectives

19. To the extent that program staff has flexibility to manage program-related activities and adapt to changing exigencies, the greater the chances that the project will achieve

    a. project objectives
    b. continuation of coalition
    c. continuation of program
    e. spread effects

20. To the extent that there have been suitable steps taken to ensure cultural appropriateness of interventions during program design, the greater the chances that the project will achieve

    a. project objectives
    b. continuation of coalition
    c. continuation of program
    d. community empowerment
    e. spread effects

21. To the extent that educational materials are culturally appropriate, the greater the likelihood that the project will achieve

    d. community empowerment

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[7] Suitable in terms of culture, community, and the nature of the health problem.

22. To the extent that suitable steps are taken to ensure cultural appropriateness of training of staff and volunteers, the greater the chances that the project will achieve

    a. project objectives
    b. continuation of coalition
    c. continuation of program
    d. community empowerment
    e. spread effects

23. To the extent that suitable steps are taken to ensure cultural appropriateness of intervention site(s), the greater the chances that the project will achieve

    a. project objectives
    b. continuation of coalition
    c. continuation of program
    d. community empowerment
    e. spread effects

24. To the extent that suitable steps are taken to ensure cultural appropriateness in implementing the program, the greater the chances that the project will achieve

    a. project objectives
    b. continuation of coalition
    c. continuation of program
    d. community empowerment
    e. spread effects

25. If the coalition has specific task forces or task-oriented subcommittees, the project is more likely to achieve

    a. project objectives

26. If the coalition includes natural community leaders that actively participate in the coalition, the project is more likely to achieve

    a. project objectives
    b. continuation of coalition
    c. continuation of program
    d. community empowerment
    e. spread effects

27. The more the coalition provides additional in-kind contributions and resources[8] to the project, the greater are the chances that the project will achieve

    a. project objectives
    b. continuation of coalition
    c. continuation of program

28. To the extent that natural community leader(s) participate in the program, the greater the chances that the project will achieve

    a. project objectives
    b. continuation of coalition
    c. continuation of program
    d. community empowerment
    e. spread effects

29. To the extent that a needs assessment[9] is conducted with target community input in developing the program design, the greater the chances that the project will achieve

    a. project objectives
    d. community empowerment

30. To the extent that there is target community participation in ongoing program implementation, monitoring, or modification, the greater the chances that the project will achieve

    a. project objectives
    b. continuation of coalition
    c. continuation of program
    d. community empowerment
    e. spread effects

31. To the extent that the program actively involves (not just attracts) community volunteers in programmatic decision-making and implementation, the greater the

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[8] Space (meeting, work); personnel/in-kind; technical assistance (training, evaluation); equipment/supplies; advertising; promotion.

[9] Needs assessment may conducted using research methods (as done in El Paso) or less formal, nonresearch methods (as done in Seattle).

chances of the project achieving

a. project objectives
b. continuation of coalition
c. continuation of program
d. community empowerment
e. spread effects

32. To the extent that the project is flexible in design and implementation, the greater the likelihood of achieving

a. project objectives

33. To the extent that program staff and volunteers adopt the health behavior change(s) being promoted[10], this provides positive role-modeling and lends credibility to the agents of behavior change, leading in turn to a greater chance that the project will achieve

a. project objectives (to the extent that behavior change is involved, which is the case with virtually all projects)

34. To the extent that the program volunteers or outreach workers adopt the behavior change(s) being promoted, this provides positive role-modeling and lends credibility to the agents of behavior change, leading in turn to a greater chance that the project will achieve

a. project objectives (to the extent that behavior change is involved)

35. To the extent that OMH provides timely and appropriate technical assistance, the greater the likelihood of achieving

a. project objectives

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[10] This may involve a subjective assessment of personal transformation for the better (cessation of drinking or smoking, loss of weight, improvement of diet, becoming a generally healthier person).

C. Multiple Case Study Analysis of 13 Site-Visited Projects

Analysis Strategy

The case material presented thus far describes the history of events and unique factors associated with each project's outcomes. In other words, individual case material provided information that is valid and relevant for a specific site. The analysis of this material, therefore, yields answers to the question "what factors account for a specific project having positive outcomes?"

While the analysis of individual cases has provided substantial insight into the richness of the context and strategies for each project's accomplishments, a great deal can still be learned from the simultaneous examination of all 13 projects visited by the Study Team. Simultaneous examination of the multiple case studies provides answers that are generally true, even though there may be exceptions. For this reason, it is important for this study to answer the question "what factors in general account for projects having positive outcomes?"

The Study Team employed the SPSS statistical analysis program and used crosstabulation procedures in order to draw conclusions about relationships between project characteristics and project outcomes across the 13 site-visited projects. The small sample size and overall sampling procedures made tests of statistical significance and other parametric statistical tests inappropriate. In addition, because this study was primarily an exploratory effort intended to generate hypotheses, hypothesis testing was not warranted.

In the following discussion, attention is focused on five project outcomes: achievement of objectives, continuation of coalition, continuation of program, community empowerment, and spread effects. Comparisons of characteristics and outcomes across projects are expressed in the form of percentages and percentage differences.

Achievement of Project Objectives

At the onset of this study it seemed reasonable to assume that factors that contributed to the cultural complexity of a project's tasks would tend to serve as obstacles to the achievement of its objectives. For example, the need to target more than one ethnic group or take account of the immigration status of members of the target population and multiple languages, seemed likely to add to the complexity of project design and implementation. Yet a systematic examination of multiple sources of data (e.g., site visits, project documentation) across the 13 projects suggests no such pattern. Projects with a medium degree of cultural complexity were 1.5 times as likely as projects with low levels of complexity to achieve a high degree of their objectives. In other words, having a relatively higher degree of cultural complexity does not decrease the likelihood of

achieving a high degree of objectives. For example, one project that served multiple ethnic groups with varying degrees of acculturation and that targeted three different age groups realized a high degree of objective achievement. While the analysis does not explain why cultural complexity does not have the predicted effect, it is quite possible that the nature of the project design and intervention strategy are more significant than complexity per se in the achievement of project objectives.

It was hypothesized that addressing target health problems with an associated social stigma (e.g., substance abuse, sex-related behavior, violence) would make more difficult the achievement of project objectives. However, this did not prove to be necessarily the case. Indeed, some projects that addressed such issues within the context of the whole target community and used culturally appropriate methods were able to both attain their objectives and achieve important spread effects. The choice of health problem may have more to do with the commitment of coalition members and project staff than anything else. Thus, tackling a health problem that is stigmatized need not serve as an obstacle, deterrent, or handicap in project design, implementation, and effectiveness, provided the approach takes appropriate account of the entire community and its culture.

What does seem to affect the achievement of objectives is a project's flexibility in design and the nature and application of evaluation procedures. Projects with a high degree of design flexibility[11] were more than twice as likely as projects with relatively low or average levels of flexibility to achieve their objectives to a high degree. For example, one project changed its evaluation design to eliminate a control group because all participating individuals wanted the benefit of the treatment. This project was able to demonstrate a high degree of achievement of objectives despite this fundamental change. Projects that empirically gathered and analyzed formative data within the first six to nine months of the project were a little more likely to have a high degree of achievement of objectives. Projects that gathered baseline data were more likely to have a relatively high degree in achieving their objectives. Projects that collected and used baseline data in the first six months more frequently achieved a high degree of their objectives as compared to those projects that did not. Projects that carried out an outcome evaluation were more likely to achieve their objectives to a relatively high degree.

Several patterns emerge from the analysis of the characteristics of coalitions and the achievement of project objectives. Coalitions that did not have task forces were more than twice as likely as coalitions with task forces to have projects that achieved their objectives to a high degree. This finding is somewhat surprising because of the commonly held assumption that small groups are more effective in involving members in decisionmaking and task completion. For this reason, it would seem that projects that

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[11] Flexibility is a matter of degree. For our purposes, flexibility is the willingness to modify the design, intervention, implementation, and evaluation. The decision to modify depends on responsiveness to community needs and cultural context.

had small enough coalitions did not need to impose a small committee structure to be effective. Small groups can work effectively as a committee of the whole.

The greater the extent to which natural community leaders representative of the target community actively participated in coalition decisionmaking and intervention program activities, the greater the degree of achievement of project objectives. Among the six projects that attained a relatively high degree of their objectives, four had natural community leaders who were in touch with and gave voice to target community needs and wishes.

The manner in which intervention programs involved the community also appeared to be related to overall achievement of project objectives. Projects that conducted a needs assessment were twice as likely to achieve a high degree of their objectives as those that did not. Projects for which there was a relatively high degree of community participation in program implementation, monitoring, or modification were more likely to achieve a high degree of their objectives.

Intervention programs whose staff demonstrated relatively high degrees of flexibility in managing activities and adapting to changing exigencies were more likely than programs with low or more modest degrees of flexibility to achieve a high degree of objectives. After realizing that there was little agreement among coalition members on project objectives, one project director held a series of focus group discussions among the target population to determine their priorities. These findings were used to reach a consensus on project objectives that all parties (target group, staff, and coalition members) embraced.

One of the most interesting patterns that emerged was the importance of community volunteers. Projects whose intervention programs were able to attract and retain volunteers to a relatively great extent were much more likely to achieve a high degree of their objectives. The greater the extent to which a program actively involved community volunteers in decisionmaking and implementation, the greater was the extent of the project's achievement of its objectives. Among projects that achieved a high degree of their objectives, five had volunteers involved to a relatively high extent, while only one had volunteers with a relatively low degree of program involvement.

Finally, the overall helpfulness of OMH in terms of providing assistance (e.g., information, resources, feedback) appeared to be related to the extent to which a project achieved its objectives. Projects that reported relatively low levels of OMH assistance less frequently achieved their objectives to a high degree as compared to others.

Continuation of Coalition

What factors are characteristic of those coalitions that continued to exist after OMH funding ended? One consistent factor was the degree to which projects took steps

to ensure the cultural appropriateness of their intervention program activities. Coalitions that undertook a relatively high degree of such steps during program design and the selection of intervention sites were almost three times as likely as others to continue after OMH funding ended.

Coalitions that persisted also tended to be associated with projects whose targeted health problem had a relatively high degree of social stigma (e.g., AIDS, teen pregnancy, homicide). Among the nine coalitions that continued after OMH funding ended, six were involved in projects that had a high degree of social stigma. Apparently, these projects took extraordinary steps to overcome the social stigma of the problem of focus.

Other project characteristics associated with coalition continuation included existence of the coalition prior to OMH funding, participation by natural community leaders in the coalition and program activities, staff reflecting target population ethnicity, program flexibility, and culturally appropriate interventions.

Continuation of Program

Intervention programs that integrated the community into their intervention strategies were more likely to continue after OMH funding ended. Projects that involved existing community-based entities (e.g., churches, schools, health care delivery systems, social services, or a combination of these) were more likely to continue after OMH funding. Also, programs that took steps to ensure cultural appropriateness tended to continue after OMH funding ended. Among the nine programs that continued, five made a high degree of effort to ensure the cultural appropriateness of interventions during program design. Programs that devoted little effort to ensuring cultural appropriateness in program design and implementation were the least likely to continue after OMH funding ended.

The degree to which programs actively involved community volunteers was also strongly associated with program continuation. Eighty percent of programs in which community volunteers were very actively involved continued after OMH funding ended. Further, in two instances, community volunteers continue to provide training, screening, and referral services although their respective projects and coalitions no longer officially exist. Moreover, in one case, community volunteers have become the coalition and maintain the program.

Community Empowerment

It seems reasonable to assume that the impact of empowerment is indicated by the degree to which communities shaped and demonstrated a sense of ownership of the projects and took responsibility for and had an impact on local health and related issues.

A high degree of ownership and shaping by the target communities of the OMH-funded projects suggests that the needs, desires and will of the community, rather than external

forces, can influence a community's destiny and how that destiny will be worked out. During the site visits, the sense of ownership was most often expressed in the form of verbal statements, expressions of pride, and attainment of new self-confidence. Shaping of the project was generally indicated by roles in developing and modifying program designs and implementations. Several factors seem to be characteristic of projects that had a high degree of expressed community shaping and ownership: Projects whose coalitions had (1) a CBO as the grantee lead organizations, (2) natural community leaders actively involved, and (3) memberships that reflected the racial/ethnic characteristics of the targeted community were more likely to express a high degree of ownership and shaping of the projects and the intervention program.

Program staff in such projects tended to reflect the racial/ethnic characteristics of the target community and to have received culturally appropriate training, although the staffs of programs that dealt with more than one population were able to work well across cultures. Gender of program staff did not seem to play an important role. Representatives of projects with actively involved community volunteers were more likely to express a high degree of shaping and ownership. For example, of the five programs that were characterized by high degrees of shaping and ownership, all had community volunteers who actively participated in program decisionmaking and activities. Programs in which there was a high degree of shaping were 1.3 times as likely to have community volunteers.

Spread Effects

Some projects not only achieved their stated objectives, but also managed to accomplish much more. These accomplishments or spread effects that extended beyond project objectives represented the efforts of committed coalition members, program staff, community volunteers, and others. Many programs moved into other health areas and even addressed nonhealth community issues. For example, one coalition in a migrant community persuaded the principal of an elementary school to hire a full-time bilingual secretary to facilitate communication between parents and the school's administration and teachers. A number of projects had their intervention programs replicated in many other settings. In one case, other government departments began to address racial/ethnic minority issues after the OMH-funded project's health department-based coalition successfully made a number of structural changes that improved service delivery to racial/ethnic minority clients and improved communication between these clients and staff. Another project's culture-specific intervention strategies were adopted both at the national and international level.

Generally, programs that incorporated community input into their structure and interventions were more likely to have spread effects. Programs with a relatively low level of involvement of natural community leaders were less likely to achieve a high degree of spread effects. The greater the degree to which programs took steps to ensure the cultural appropriateness of intervention during program design, the greater the spread

effects. Eighty percent of the programs in which community volunteers were involved had a high degree of spread effects.

V. CONCLUSIONS AND RECOMMENDATIONS

The Study Team compiled and reviewed a considerable amount of secondary documentary data on the 26 projects funded under the 1986-1989 OMH Community Health Coalition Demonstration Grant Program Projects. However, the richest and most complete information was collected through the conduct of site visits to 13 of the projects. Therefore, the following conclusions and recommendations are based on information gathered during the course of the site visits, together with insights gained through discussions with past and present OMH Project Officers, as well as through comments and recommendations made by representatives of 24 of the 26 projects during a conference held at the close of the study.

A. Conclusions for Projects:

During the course of the study, a number of hypotheses were generated that require further testing. Perhaps the most valuable result of this exercise was the emergence of a set of characteristics that in combination are likely to enable projects to attain five desirable outcomes: (1) achievement of project objectives, (2) coalition continuation, (3) program continuation, (4) community empowerment, and (5) spread effects. These project characteristics are as follows:

1. Delineation of project goals and objectives that are clear, feasible, and achievable.

2. Designation of a CBO that meets all criteria for funding as the grantee and coalition lead entity.

3. Ensuring CBO membership in the coalition and active participation in intervention program activities.

4. Active involvement of recognized, respected community leaders in coalition decisionmaking and program activities.

5. Ensuring that a majority of coalition members and project staff have first-hand familiarity with the culture and language of the target community and reflect the ethnicity of the target population.

6. Early attention to the evaluation component, including the collection of baseline data and the conduct of formative research.

7. Engagement of the target community in all aspects of the program, including needs assessment, design, implementation, and ongoing monitoring of activities.

8. Shaping the program's design and implementation to the target community to ensure maximum cultural appropriateness and flexibility in all aspects of the program (e.g., selection of intervention sites, outreach strategies, and development of educational and training materials).

9. Active involvement of community volunteers and/or community consultants[12] in program design, implementation, and evaluation.

10. Receipt of OMH technical assistance as needed during each critical phase of application preparation and program design, implementation, and evaluation.

Conclusions for OMH

1. Analysis of the 26 grant applications selected for funding between 1986 and 1989 revealed that there was a wide variation in the feasibility and measurability of the project objectives and the sophistication and appropriateness of evaluation plans. Further, applications often contained incomplete demographic information and presented unclear rationales for the selection of the risk factors to be addressed and intervention strategies to be employed. On the whole, the applications improved in these respects during the funding period.

   Concurrently, OMH application guidelines became more clearly delineated during this period. For example, the 1986 RFA only briefly mentioned evaluation--"An evaluation plan will enable the coalition to assess the effects of its interventions upon each of the risk factors and target populations." This guidance was amplified in 1987 when weights were assigned to application review criteria for the first time in 1988 evaluation accounted for 25% of an applicant's score or rating. In fact, by 1991 the RFA posed a set of pointed questions: "What interventions are being provided and to whom?" "What are the factors that facilitate or inhibit the implementation of the coalition?" and "What factors facilitate or inhibit the sustainability of the coalition?"

2. Five (38 percent) of the project grantees visited on site expressed the feeling that OMH had been helpful and responsive during the funding periods. They also appreciated the freedom they had to shape their projects on the basis of local circumstances. However, they all indicated that they would have liked more time and funding to carry out their projects.

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[12] These are usually nonprofessional individuals from the target population who are knowledgeable about most aspects of their community. This term implies that they will be compensated for their expertise.

OMH has since taken steps to address these issues. In 1991, the grant period was extended from two to three years and the funding level was raised from $100,000 per year to $200,000 per year. Moreover, instead of being restricted to a list of seven health problems from which to select a health problem to be addressed, applicants have been allowed to focus on any documented health problem of concern to their communities.

3. A majority of the site-visit projects indicated that they would have welcomed more OMH technical assistance during the application preparation, evaluation design, and/or early program implementation phases of their projects. They also felt that more feedback on progress reports would have been helpful.

   It should be noted that during the period under review OMH provided pre-award technical assistance to applicants who initiated contact with the appropriate OMH officer identified by name in the RFA, and to potential applicants who attended OMH-initiated regional workshops. An average of 145 applications a year were received in the first four years of the Coalition Demonstration Grant Program (1986-1990). Given this volume of interest and the fact that the first two OMH Project Officers had little administrative support, providing pre-award technical assistance presented a tremendous challenge. Moreover, OMH must ensure that its pre-award technical assistance is even-handed so that it does not appear to favor a particular applicant. Since 1990, two additional OMH resources for technical assistance have been added: 10 Regional Minority Health Consultants, and the Grants Management Office.

B. Recommendations

Recommendations for Projects

1. To the degree feasible, incorporate into project design the above 10 project characteristics associated with positive outcomes.

2. Perform a community needs assessment at the outset of the project by collecting available demographic and epidemiological data and employing rapid assessment methods (e.g., focus groups) with the target community members to form a basis for developing the intervention program design, and repeat the assessment periodically to ensure that the program is meeting the perceived needs of the community.

3. Where there is need, design programs that effectively take into account existing cultural complexity, i.e., involve one or more languages requiring translation, focus on an immigrant population, or involve more than one racial/ethnic minority population or subpopulation and make sure these factors are addressed in the design.

4. In addressing a health problem that bears an associated social stigma, such as substance abuse, sexually related behavior, and violence, ensure that the design is well thought out and responsive to all elements of the target community.

5. If one of a project's objectives is increased access to health care services, include representatives of the health care establishment who have authority, or the delegated authority, to actually influence, and if necessary modify the health care system.

6. Maximize in-kind assistance that members' organizations contribute to the project, such as meeting space, equipment, transportation, educational materials development, advertising, training, clinical services, and evaluation research.

7. Ensure that intervention sites are accessible to the target population in terms of cultural suitability, language, transportation, and accommodation for the disabled.

8. Utilize all available resources, including OMH, for needed technical assistance during application preparation, program design and implementation, and evaluation.

9. Contact the OMH Resource Center to secure information relevant to racial/ethnic minority populations and utilize its media databases, publications, journal articles, and information on funding sources.

10. Communicate with other projects--OMH funded or otherwise--to share experiences and compare approaches in addressing similar target populations and health problems.

Recommendations for OMH:

1. Consider further expanding the project funding period from three to five years. The first two years could be devoted to planning, coalition organization, baseline data gathering and formative evaluation, and staff capacity building. Projects which achieve a high level of performance during the first two years would be eligible for an additional three years of OMH support.

2. Strengthen the application review process to ensure that the applications selected for funding are technically sound and contain the above-noted project characteristics. Ensure that grant reviewers have the requisite technical skills and sociocultural expertise necessary to review OMH Minority Community Health Coalition Demonstration Grant Program applications.

3. Strengthen evaluation guidelines by instructing projects to conduct baseline and formative evaluation. Most projects need technical assistance in this crucial area. It could come from OMH (central or regional offices) or from a contractor; in any case, OMH should have in-house capability to evaluate the design of baseline and formative research.

4. Build into management of the grant program outside process evaluation/monitoring, with technical assistance to be rendered as necessary. This should start during initial project development and continue on a regular basis.

5. Develop additional mechanisms to provide timely and appropriate technical assistance at critical points in the life the projects: grant application and project design (and possibly re-design), budget development, baseline and formative research, documentation for project monitoring, and evaluation.

6. Consider the establishment of separate funding devoted to the evaluation of projects and provision of appropriate technical assistance.

7. Continue to strengthen periodic reporting systems. Project Officers should provide regular feedback on periodic reports and conduct annual site visits to projects.

8. Involve OMH Regional Minority Health Consultants in providing technical assistance and administrative support to projects.

9. Direct the OMH Resource Center to establish a project evaluation database and to acquire samples of software used by projects in all OMH grant programs.

10. Strengthen the OMH Resource Center services to projects racial/ethnic communities by a) establishing a film and video library on health topics/issues relevant to racial/ethnic minority communities; b) allowing applicants and grantees to tap the Resource Center's information database directly through computer link-up; c) publishing a grantee newsletter to facilitate networking and the sharing of information; and d) ensuring the participation of a Resource Center representative in all annual grantee meetings to provide updates on available information and services.

11. Improve coordination and information sharing within the DHHS and with other Federal agencies that provide assistance and support to racial/ethnic minority communities.

12. Conduct research to test the hypotheses generated by this study with a number of racial/ethnic minority health projects.

Many of the hypotheses that were inductively derived from the site visits made during this study touch upon crucial policy and program issues. Therefore, a testing of these hypotheses should be of considerable interest to policy-makers, planners, and others in a number of government agencies that support community-based projects in the health and social service sectors. It is recommended that the tentative hypotheses that emerged in this study be circulated to such agencies with a view toward interagency collaboration and perhaps joint sponsorship of a broader study.

C. Recommendations for Future Research

This study has entailed a careful examination of processes and outcomes critical to the OMH Minority Community Health Coalition Demonstration Grant Projects (1986-1989). Many findings from this research have supported conventional wisdom regarding community involvement, participation, and empowerment through coalition development. It is important, however, that future research continue to advance our knowledge beyond conventional wisdom so that health policies and programs can effectively serve diverse racial/ethnic minority communities. Listed below are five recommendations for future research.

1. Determine what coalition models are most effective in terms of achieving the five outcome variables listed in this report. Give attention to coalition members' prior relationships, statuses, roles within the community, differing agendas, and reasons for joining the coalition (both explicit and implicit). Determine the relationship of the size, composition, and functions of coalitions to the interactional dynamics and outcomes of coalition effects. Special focus should be placed on sociocultural differences and similarities that may influence the ways various minority communities shape and sustain coalitions.

2. Determine whether, how, and to what degree effective intervention program designs are relevant within a specific sociocultural context. The objective would be to develop an ethnic-specific design for implementing effective intervention programs that could, with modifications, have crosscultural applicability.

3. Determine which coalition models and interventions are most effective in achieving health-related behavior change in the target populations.

4. Determine how natural community leaders assist projects in achieving their stated objectives. Research should distinguish between the effects of mere inclusion in the coalition and active participation in guiding the project.

5. Determine the extent to which projects can attract and retain volunteers, and the degree to which the roles and activities of those volunteers enable projects to achieve coalition continuation, intervention program continuation, community empowerment, and spread effects.

OFFICE OF MINORITY HEALTH
MINORITY HEALTH COALITION
DEMONSTRATION GRANT PROGRAM (1986-1989)
MULTIPLE CASE STUDY

FINAL REPORT

VI. APPENDICES

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APPENDIX A

OMH MINORITY COMMUNITY HEALTH COALITION DEMONSTRATION GRANT (1986-1989)
PROJECT INFORMATION AND SYNOPSIS

*** site visit projects**

Project Name: Multicultural Community Health Coalition Project
Award Year: 1986
Location: San Jose, CA **Region:** IX
Number: D52 MP 00014
Lead Organization: San Jose State University
Type of Organization: University
Target Population: Hispanic, Asian, and Black
Target Health Risk Area: Health Promotion
Major Interventions: Establishment of multicultural community coalition. Trained health professionals to become more culturally sensitive.
Brief Synopsis: The intent of this project was to affect risk reduction by establishing a multicultural community health coalition in San Jose among members of community organizations, agencies, health professionals, and interested citizens. The coalition developed and coordinated health promotion programs and activities aimed at improving the health of Asian/Pacific Islander, Black, and Hispanic minorities.
Post Funding Status: Each sub-committee continued as a distinct coalition (i.e. AIDS, Chemical Dependency, Teenage Pregnancy, Health Education / Training).
Contact: William Washington, San Jose State Univ., Dept. of Health Sciences, (408) 924-2970.

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Project Name: Reducing Risk for Diabetes Among Mexican Americans
Award Year: 1986
Location: Los Angeles, CA and Dallas, TX **Region:** VI, IX
Number: D52 MP 00047
Lead Organization: COSSMHO (The National Coalition of Hispanic Health and Human Service Organizations)
Type of Organization: Non-Profit Organization
Target Population: Hispanic
Target Health Risk Area: Diabetes and Diet
Major Interventions: **Dallas -** Media campaign conducted to recruit people to participate in awareness classes about diabetes (e.g., news releases, tv spots, radio show, etc.) and to participate in an eight week session on diabetes / health awareness, and weight loss. **Los Angeles -** See above, plus blood glucose screening.
Brief Synopsis: This project focused on weight control through improvement of nutrition and diet. This project combined the resources of the American Red Cross, the American Diabetes Association, and local community health centers in order to increase knowledge about obesity and other risk factors affecting the lives of Mexican Americans.
Post Funding Status: **Dallas:** Coalition continued. **Los Angeles:** Information Not Available.
Contact: Horace Sarabia, Los Barrios Unidos Community Clinic, Dallas, TX, (214) 651-8691.

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Project Name: Accidental Injury Control Minority Health Project of Lumberton, NC*
Award Year: 1986
Location: Robeson County, Lumberton, NC **Region:** IV
Number: D52 MP 00021
Lead Organization: Robeson County Health Department
Type of Organization: Health Department
Target Population: Black and Native American
Target Health Risk Area: Accidental Injury
Major Interventions: SAFEHOME visits: installed passive safety devices and provided information on home safety precautions. Distributed educational materials, conducted health fairs, counseling, and provided smoke detector and fire extinguisher installation.
Brief Synopsis: This project was designed to reduce the number of unintentional injuries such as accidental poisonings, burns, motor vehicle accidents, firearm injuries, falls and environmental hazards in minority populations in rural Robeson County. The Robeson County coalition sponsored volunteers to conduct safe home visits, make passive safety devices, and make available injury prevention counseling.
Post Funding Status: Establishment of county-wide injury prevention program.
Contact: Connie Scott, Robeson County Health Dept., Lumberton, NC, (919) 671-3200.

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Project Name: Minority Hypertension Detection and Control Program*
Award Year: 1986
Location: Cleveland, OH **Region:** V
Number: D52 MP 00019
Lead Organization: The Greater Cleveland High Blood Pressure Council
Type of Organization: Non-Profit Organization
Target Population: Hispanic and Black
Target Health Risk Area: Hypertension
Major Interventions: Blood pressure screenings.
Brief Synopsis: This project expanded the activities of the Greater Cleveland High Blood Pressure Coalition to include developing a system that provided access to screening services and reached high risk Hispanic and Black males.
Post Funding Status: The High Blood Pressure Council of Greater Cleveland is now run out of Mt. Sinai Medical Center. The structure of the coalition is now an Advisory Committee which has expanded in size to increase the range of community input and involvement.
Contact: Joyce Lee, High Blood Pressure Council of Greater Cleveland, (216) 421-6453.

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Project Name: Diet-Smoking-Blood Pressure Control for Blacks in Nashville Blacks
Award Year: 1986
Location: Nashville, TN **Region:** IV
Number: D52 MP 00029
Lead Organization: Meharry Medical School
Type of Organization: University
Target Population: Black
Target Health Risk Area: Diet, Smoking and High Blood Pressure
Major Intervention: Trained and utilized Church Health Aides to take blood pressure, weight and offer support to at-risk population. Diet, obesity, blood pressure, and smoking cessation classes were offered. Food fares and co-ops were conducted at local churches.

Brief Synopsis: Addressing two problems, cancer and cardiovascular disease, the coalition sponsored by Meharry Medical College initiated a program addressing specific risk factors of diet, obesity, smoking, and high blood pressure among Blacks. The project objectives were to transform existing preventive and promotion programs related to reducing these risk factors into a Black framework and implement them through Black community networks and interventions.
Post Funding Status: Project continued with funding from an NCI grant.
Contact: Margaret Hargreaves, Meharry Medical College, Nashville, TN, (615) 327-6212.

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Project Name: ACOA Indian Alcohol Prevention Team*
Award Year: 1986
Location: Seattle, WA **Region:** X
Number: D52 MP 00067
Lead Organization: Seattle Indian Health Board
Type of Organization: Community Based Organization
Target Population: Native American
Target Health Risk Area: Alcohol
Major Intervention(s): Trained counselors (chosen community members) to conduct ACOA intervention and maintain support groups. Produced newsletter, and utilized cultural components in program.
Brief Synopsis: ACOA Indian Alcohol Prevention Team was first sponsored by the Seattle Indian Health Board. This project targeted health problems associated with alcoholism and alcohol abuse in the Native American community in the Seattle, Washington area. Indian counselors were trained to address alcohol misuse and to intervene in the effects of intergenerational cultural depression and family dysfunction.
Post Funding Status: The project is now continuing through an organization called National Association of Native American Children of Alcoholics (NANACOA).
Contact: Anna Latimer, NANACOA, Seattle, WA, (206) 454-2092.

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Project Name: Pueblo Hispanic Heart Risks: Diet, Obesity, and Exercise of Pueblo, Colorado
Award Year: 1987
Location: Pueblo, CO **Region:** VIII
Number: D52 MP 00256
Lead Organization: Pueblo City-County Health Department
Type of Organization: Health Department
Target Population: Hispanic
Target Health Risk Area: Obesity, Exercise and Cardiovascular Disease
Major Intervention(s): Health screenings measured diet, physical activity, height, weight, body fat, blood pressure (for hypertension), and blood glucose and serum cholesterol levels. Curriculum focused on diet, health, exercise, and personal development and was taught at industrial worksites, college campuses, and churches.
Brief Synopsis: Sponsored by the Pueblo City-County Health Department and the Pueblo Cardiovascular Disease Prevention Coalition, this program targeted the occurrence of cardiovascular disease in the Hispanic community. The project design included a culturally relevant curriculum on developing healthy lifestyles among young Hispanic family members.
Post Funding Status: Project did not continue beyond funding.
Contact: Gerri Alfonso, Pueblo Health Dept., Pueblo, CO, (719) 544-8376.

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Project Name: Community Coalition Project to Reduce Cancer in the District of Columbia's High Risk Minority Population*
Award Year: 1987
Location: Washington, DC **Region:** III
Number: D52 MP 00230
Lead Organization: Commission of Public Health, Bureau of Cancer Control
Type of Organization: Health Department
Target Population: Black
Target Health Risk Area: Cancer
Major Intervention(s): Baseline telephone KAP survey taken, followed by media campaign to raise community awareness about cancer and cancer screenings (i.e. posters on cancer screening, smoking prevention and cancer tips for buses, churches, schools, and neighborhood health centers.) "Know Your Body" curriculum taught at elementary schools.
Brief Synopsis: This program utilized a broad coalition of governmental agencies, private cancer organizations, and community groups to focus on the high incidence of cancer mortality among Blacks living in the District of Columbia. Intervention methods included campaigns in elementary schools, newsletters, Metrobus posters, cancer tip cards, and cancer screening activities.
Post Funding Status: The consortium obtained 501 C(3) status by the end of OMH funding and secured a three year grant for breast and cervical cancer screening.
Contact: Patricia Theiss, Bureau of Cancer Control, Washington, DC, (202) 576-8893.

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Project Name: Asian Cancer Awareness Project*
Award Year: 1987
Location: Boston, MA **Region:** I
Number: D52 MP 00003
Lead Organization: South Cove Community Health Center
Type of Organization: Community Based Organization
Target Population: Asian
Target Health Risk Area: Cancer
Major Intervention(s): A two-phase workplace intervention was presented on hypertension, cholesterol, smoking cessation and alcoholism to Chinatown restaurant employees. A post-testing questionnaire and presentation on cancer were conducted. An outreach program was advertised in articles and newsletters, and conducted through community events and door-to-door visits.
Brief Synopsis: A coalition of five Chinatown restaurant owners, an advisory committee of restaurant workers, and the South Cove Community Health Center formed to educate Chinese adult male restaurant workers about risk behaviors and nutritional issues associated with cardiovascular and cerebrovascular cancer.
Post Funding Status: Coalition did not continue.
Contact: Esther Lee, South Cove Community Health Center, Boston, MA, (617) 654-2957.

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Project Name: The Coalition SHARE Harlem Hospital Project
Award Year: 1987
Location: New York City, NY **Region:** II
Number: D52 MP 00195
Lead Organization: Memorial Sloan-Kettering Cancer Research Center

Type of Organization: Medical Institution
Target Population: Hispanic and Black
Target Health Risk Area: Health Promotion/Cancer
Major Intervention(s): SHARE program conducted in conjunction with cancer screening. Three components of program, 1) information, 2) community service, and 3) food package incentives.
1) Modified (6th grade level) reading material on diet/nutrition and cancer screening utilization distributed, along with "Health Times" calendar.
2) Community service manuals published to help implement other cancer prevention and health promotion efforts.
3) Voucher for free food package upon completion of free cancer screening given to at-risk population.
Brief Synopsis: The objectives of this project were to alter dietary practices in order to reduce the risks of cancer and increase the utilization of cancer screening services in the Harlem community of New York. Led by the Sloan-Kettering Cancer Center and Harlem Hospital, this health promotion effort used a community empowerment process to develop self-help, community and individual education programs, cancer screenings and referrals.
Post Funding Status: Project continued with support from the State of New York, and NCI.
Contact: Jon Kerner, Geogetown Univ. Medical Center, V. Lombardi Cancer Research Ctr., Washington, DC, (202) 687-2186.

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Project Name: The El Paso Coalition for Hispanic Health Promotion of El Paso*
Award Year: 1987
Location: El Paso, TX **Region:** VI
Number: D52 MP 00103
Lead Organization: Paso Del Norte Area Health Education Center/Texas Tech University
Type of Organization: University
Target Population: Hispanic
Target Health Risk Area: Diabetes and Obesity
Major Intervention(s): Intervention model called "Paso-A-Paso" was developed as an eight week weight loss program centered on learning skills and behavior modification. Posters, radio dramas, and bilingual booklets incorporating "folk concepts" developed as companion to eight week program.
Brief Synopsis: This project was sponsored by a number of community organizations, service providers, civic leaders, and neighborhood support groups. Paso del Norte Area Health Education Center utilized focus group discussions to target the Hispanic population's high incidence of diabetes. The educational program was aimed at reducing obesity and controlling weight through proper diet and exercise in the Mexican American community.
Post Funding Status: Coalition did not continue, however, the Paso A Paso program remains ongoing at sites in El Paso, Austin, San Antonio, and Juarez, Mexico.
Contact: Beatriz Vera, AHEC, El Paso, TX, (915) 545-6551.

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Project Name: Cardiovascular Disease Risk Reduction Campaign of Seattle
Award Year: 1987
Location: Seattle, WA **Region:** X
Number: D52 MP 00172
Lead Organization: Central Seattle Community Health Centers
Type of Organization: Community Based Organization
Target Population: Black
Target Health Risk Area: Cardiovascular

Major Intervention: Business and church-based multi-risk factor screening (blood pressure, cholesterol, height, weight, healthy history questionnaire) provided. Health promotion efforts concentrated in Black churches. Other education efforts included articles, radio promotion, and heart disease presentations.
Brief Synopsis: This campaign targeted the reduction of morbidity and mortality from cardiovascular disease in the Seattle Black community. The Sound Heart Program, as part of the Central Seattle Community Health Center, led interventions including a media campaign involving Black institutions and personnel, and a multi-risk factor screening service.
Post Funding Status: Coalition did not continue.
Contact: Linda Jones, Central Seattle Community Health Center, Seattle, WA, (206) 461-6900.

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Project Name: Yolo County Ayude Su Corazon/Help Your Heart Community Coalition*
Award Year: 1988
Location: Sacramento, CA **Region:** IX
Number: D52 MP 00278
Lead Organization: Hypertension Council of the American Heart Association
Type of Organization: Community Based Organization
Target Population: Hispanic Adults
Target Health Risk Area: Cardiovascular Disease and Hypertension
Major Intervention(s): Blood pressure and cholesterol screenings provided, as well as bi-lingual public service announcements (PSA's), and other written material. Grocery Education Program started at local grocery stores included recipe flyers, bag stuffers, and bi-lingual tape recorded announcements.
Brief Synopsis: Ayude Su Corazon is a bilingual program which was designed to educate Hispanic adults in six rural counties about risk factors associated with cardiovascular disease and stroke. Interventions included blood pressure and cholesterol screening, risk factor education and detection, referral, and follow-up services.
Post Funding Status: State funds were secured to provide health education in the areas of smoking cessation, HIV/AIDS, and nutrition. The Health Education Council is now a non-profit CBO.
Contact: Debra Oto-Kent, Health Education Council, Sacramento, CA, (916) 556-3344.

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Project Name: Health Promotion Program for Blacks in Jackson County
Award Year: 1988
Location: Tallahassee, FL **Region:** IV
Number: D52 MP 00263
Lead Organization: Area Agency on Aging for North Florida, Inc.
Type of Organization: Community Based Organization
Target Population: Black
Target Health Risk Area: Health Promotion and Cardiovascular Disease
Major Intervention(s): Church-based activities included health and blood pressure screenings, exercise videos and classes (GOSPELSIZE), and culturally-specific manuals for developing a church-based program. Coalition sub-committee sponsored grant-writing workshops, and media campaigns to promote health activities.
Brief Synopsis: This program targeted risk factors such as hypertension, improper diet, tobacco use, and obesity, and provided a cardiovascular disease health promotion program to elderly Black residents in Jackson County, Florida. Intervention strategies included conducting health needs assessments and implementing health promotion activities in churches throughout the community. Members of the

coalition included county, community, and governmental organizations as well as churches, colleges, and universities in the area.
Post Funding Status: The American Heart Association sponsored the continuation of the project.
Contact: Mary Sutherland, Area Agency on Aging, Tallahassee, FL, (904) 488-3352.

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Project Name: Kansas Black and Hispanic Coalition on Infant Mortality*
Award Year: 1988
Location: Topeka, KS **Region:** VII
Number: D52 MP 00200
Lead Organization: Kansas Dpt. of Health and Environment, Bureau of Family Health
Type of Organization: Health Department
Target Population: Black and Hispanic
Target Health Risk Area: Infant Mortality
Major Intervention(s): Community Health Educators (CHEs) were trained by public health nurses to educate, inform and assist women in providing themselves and children with health care. CHEs conducted home visits, focus group discussions, and distributed written materials.
Brief Synopsis: In establishing the Black and Hispanic Community Health Coalition Steering Committee, this project sought to reduce infant mortality in three targeted urban counties in eastern Kansas. Intervention methods included the use of a bicultural primary prevention home management model to address behavior factors in order to decrease neonatal and postneonatal mortality.
Post Funding Status: State support helped the continuation of outreach in two counties. The coalition board was transformed into the of Kansas Multi-Ethnic Advisory Commission on Health.
Contact: Azzie Young, Kansas Dept. of Health & Environment, Topeka, KS, (913) 296-5795.

* * * *

Project Name: An AIDS Prevention Project for Blacks*
Award Year: 1988
Location: New Orleans, LA **Region:** VI
Number: D52 MP 00318
Lead Organization: New Orleans Department of Health
Type of Organization: Health Department
Target Population: Black
Target Health Risk Area: AIDS
Major Intervention(s): Basic AIDS outreach included sponsorship of health fairs, AIDS awareness days, and media campaign (fliers, posters, ads). Coalition sponsored presentations on AIDS prevention to detox units, schools, housing projects, community centers, and church groups. The coalition also sponsored HIV Antibody testing, pre and post counseling and information and screening services.
Brief Synopsis: To increase the Black community's general knowledge about AIDS and AIDS prevention, this program extended, expanded, and complemented the impact of the New Orleans Department of Health's AIDS Prevention Program. The coalition involved eight professional, tenant, gay, and theater organizations and utilized presentations, community outreach, lectures, door-to-door canvassing, and newspapers to carry out its goal of reducing the incidence of AIDS among Blacks.
Post Funding Status: PREVAIL continued, with reduced funding, through the New Orleans Department of Health.
Contact: Keith Wells, New Orleans Dept. of Health, New Orleans, LA, (504) 565-7435.

* * * *

Project Name: Community Coalition to Prevent Black Homicide*
Award Year: 1988
Location: Boston, MA **Region:** I
Number: D52 MP 00294
Lead Organization: Boston Department of Health and Hospitals
Type of Organization: Health Department
Target Population: Black
Target Health Risk Area: Homicide
Major Intervention(s): Community coalition outreach included various presentations on violence prevention to community centers, youth groups, church groups and concerned parents group. Project provided violence prevention training at youth summer camps and trained peer leaders.
Brief Synopsis: The coalition consisted of a Black church, a health care center, a multi-service center, a YWCA, and a health promotion program. They sought to train health and human service providers to work with youth on violence risk-reduction activities in three areas of Boston. The coalition was formed in order to institutionalize health education activities at each respective agency and organization.
Post Funding Status: The Violence Prevention Project is lead agency on a federal Maternal and Child Health grant in collaboration with the Massachusetts Department of Health to expand coalition activities in Boston. The coalition was replicated in Lawrence, Mass.
Contact: Linda Hudson, Violence Prevention Project, Boston, MA, (617) 534-5196.

* * * *

Project Name: Heart Health for Southeast Asians in Franklin County, Ohio
Award Year: 1988
Location: Columbus, OH **Region:** V
Number: D52 MP 00287
Lead Organization: The Ohio State University Research Foundation
Type of Organization: University
Target Population: Asian
Target Health Risk Area: Cardiovascular Disease and High Blood Pressure
Major Intervention(s): Produced culturally appropriate video tapes with health commercials and wall calendars with language-specific heart health messages. Trained indigenous heart health promotion peer counselors to help conduct blood pressure / health screening. Media/promotion materials used (fliers, grocery bag stuffers, videos, articles, public service announcements).
Brief Synopsis: Trained volunteers representing the Cambodian, Laotian, and Vietnamese communities, were central to this program which implemented a plan for reduction in cardiovascular disease among Southeast Asians in the Greater Columbus, Ohio area. The plan focused on diet, blood pressure screening, and follow-up. The coalition consisted of community-based organizations, and health agencies.
Post Funding Status: There is now an expanded grant program funded by the federal and state governments, and the program is run by the Columbus Area Refugee Task Force. The project is in it's third generation of funding since the OMH grant.
Contact: Moon Chen, Ohio State University, Dept. of Preventive Medicine, Columbus, OH, (614) 293-3920.

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Project Name: Cherokee Nation Coalition for Diabetes Prevention
Award Year: 1988
Location: Tulsa, OK **Region:** VI
Number: D52 MP 00312
Lead Organization: Oklahoma State University, College of Osteopathic Medicine

Type of Organization: University
Target Population: Native American
Target Health Risk Area: Diabetes
Major Intervention(s): Community Health Representatives were trained to offer diabetes information and outreach/education. Conducted exercise programs, screening/detection services, health fairs, and summer camp programs. Materials made included a Cherokee videotape, revision of a cookbook, and an instructional coloring book for children.
Brief Synopsis: Interventions that included health education video tapes, a re-issued Cherokee cookbook, health fairs, and diabetes screenings highlighted this coalition-based project. The project targeted risk factors such as obesity, diet, and sedentary lifestyle in order to address the incidence of Type II diabetes among the people of the Cherokee Nation. The core coalition combined resources from organizations such as area health education centers, a Cherokee health clinic, and a state college.
Post Funding Status: The coalition planned to continue at the end of the grant period, despite no guaranteed future funding. Coalition efforts were extended to other health problem areas for Native Americans.
Contact: J.C. Doggett, Oklahoma State Univ., College of Osteopathic Medicine and Surgery, Tulsa, OK (918) 582-2581.

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Project Name: Fort Defiance Area Native American AIDS Education Project
Award Year: 1989
Location: Fort Defiance, Window Rock, AZ **Region:** IX
Number: D52 MP 00608
Lead Organization: Navajo Nation Family Planning
Type of Organization: Community Based Organization
Target Population: Native American
Target Health Risk Area: AIDS
Major Intervention(s): Trained and certified an AIDS/HIV counselor to conduct prevention education at Tribal enterprises, schools, and community locations. Produced AIDS Education Kit, video tapes and posters. Utilized Native Healers as consultants in prevention education.
Brief Synopsis: In order to reduce the risk-taking behaviors associated with AIDS in this rural area, the project utilized the services of a certified AIDS counselor and educator who had knowledge of Native American healing principles and techniques. A variety of methods, which included the use of audio visual materials, posters, pamphlets, and information sharing sessions were employed by the AIDS counselor and educator in order to target high school and adult-age citizens.
Post Funding Status: The project merged into the Navajo Nation AIDS Network, which includes all Navajo groups in Arizona and New Mexico.
Contact: Penny Emerson, Native Resources, Inc., Window Rock, AZ, (602) 871-4663.

* * * *

Project Name: San Diego Samoan Community Exercise for Better Health Project*
Award Year: 1989
Location: San Diego, CA **Region:** IX
Number: D52 MP 00515
Lead Organization: Union of Pan Asian Communities
Type of Organization: Community Based Organization
Target Population: Samoan
Target Health Risk Area: Obesity and Exercise

Major Intervention(s): Exercise program led by trained exercise leaders. Media campaign conducted utilizing posters, church notices, presentations in households, and in small group church meetings. Health screening conducted (blood pressure, pulse rate, medical history, height, weight).
Brief Synopsis: Organized by the Union of Pan Asian Communities, this program targeted underactivity as a health risk which causes obesity among Samoans. An exercise intervention, led by lay exercise leaders recruited from the community, included group activities preceded by general health education and health promotion discussions and individualized home exercises. The program was organized to include outreach, assessment and screening, training, initial intervention, maintenance, evaluation, and reporting and dissemination.
Post Funding Status: The exercise program continued at various levels in the five Samoan churches, but the coalition no longer formally exists.
Contact: Margaret Iwanaga-Penrose, Union of Pan Asian Communities, San Diego, CA, (619) 232-6454.

* * * *

Project Name: AIDS: Impacting Black Deaf Persons in the Washington, DC Area
Award Year: 1989
Location: Washington, DC **Region:** III
Number: D52 MP 00587
Lead Organization: Deafpride, Inc.
Type of Organization: Community Based Organization
Target Population: Black and Deaf Individuals
Target Health Risk Area: AIDS
Major Intervention(s): AIDS surveys conducted and prevention education given. AIDS-oriented materials disseminated.
Brief Synopsis: Deafpride, Inc., of Washington, DC, trained key service providers in order to create a model of AIDS prevention for Black Deaf communities across the country. Black Deaf persons were trained to be AIDS educators and peer counselors who could address issues about AIDS, and who could communicate information about AIDS prevention. This project uncovered knowledge, attitudes, and beliefs about AIDS in the Washington, DC Black Deaf community.
Post Funding Status: The coalition and project did not continue after funding.
Contact: Margaret Bibum, Deafpride, Inc., Washington, DC, (202) 675-6700, TTY Connection Service (202) 855-1000.

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Project Name: Black Infant Mortality in Fulton and Terrell Counties, Georgia*
Award Year: 1989
Location: Fulton and Terrell Counties, GA **Region:** IV
Number: D52 MP 00282
Lead Organization: CONTINUUM: Alliance for Healthy Mothers and Children
Type of Organization: Non-Profit Organization
Target Population: Black
Target Health Risk Area: Infant Mortality
Major Intervention(s): Teens in Action was a program which trained local teen leaders how to inform peers about pregnancy, STD's and accessing community support services. The POWER line was an existing service which was a statewide hot line for pregnant mothers, and the Resource Mothers were volunteer church women who served as a maternal support system for pregnant teens.
Brief Synopsis: This program supported a coalition of organizations concerned with implementing a comprehensive pregnancy prevention program in both an urban (Fulton County) and rural (Terrell county) location. Local teens, trained "resource mothers", a referral hotline for pregnant women and

young mothers, and a health department-based program comprised the specific intervention strategies which helped to reduce the risk of infant mortality attributed to adolescent pregnancy and childbearing.
Post Funding Status: The coalition persists in a different form with monies from the state and various foundations. The coalition's rural component and minority focus has weakened.
Contact: Elaine Baker, Albany State College, Albany, GA, (912) 430-4694.

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Project Name: Coalition to Reduce Cardiovascular Disease in the Black Community
Award Year: 1989
Location: Wayne County, MI **Region:** V
Number: D52 MP 00109
Lead Organization: Wayne County Health Department
Type of Organization: Health Department
Target Population: Black
Target Health Risk Area: Cardiovascular Disease
Major Intervention(s): Conducted cardiovascular screening, nutrition and weight reduction classes, free and low-cost referrals for nutrition and weight loss, general medical service, and smoking cessation. Outreach efforts included posters, fliers, and public service announcements.
Brief Synopsis: A cardiovascular risk screening program for 5,000 Black Wayne County adults was the focus of this coalition's effort. The core coalition membership included a civil rights organization, a Black dietitians' organization, five hospital groups, a Black nurses' association, and an evaluation expert from the University of Michigan School of Public Health. Over 60 additional community agencies contributed to this project.
Post Funding Status: Not Available.
Contact: Cynthia Taueg, Wayne County Dept. of Health, Westland, MI (313) 467-3352.

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Project Name: Community Partnership for the Prevention of Alcohol and Drug Problems Among Latino Youth in Perth Amboy, New Jersey*
Award Year: 1989
Location: Perth Amboy, NJ **Region:** II
Number: D52 MP 00522
Lead Organization: University of Medicine and Dentistry of New Jersey, Robert Wood Johnson Medical School
Type of Organization: University
Target Population: Latino Youth
Target Health Risk Area: Alcoholism and Drug Abuse
Major Intervention(s): Alcohol, tobacco and drug presentations conducted at schools, churches, and other community organizations. Peer leadership and parent groups were organized and community forums for Perth Amboy residents were held. Products produced included a newsletter, brochures, a calendar, and a Directory of Services for teens.
Brief Synopsis: A multi-disciplinary education and training team delivered services to help reduce the risk of alcohol and other drug problems among high-risk, urban Latino children and youth in Perth Amboy, NJ. Increased community awareness, education, and improved utilization of prevention programs were the focus for this community coalition.
Post Funding Status: The program obtained continuation funding from the Center for Substance Abuse Prevention in 1990, for five years.
Contact: Marilyn Aguirre-Molina, Univ. of Medicine and Dentistry of New Jersey, Dept. of Environmental and Community Medicine, Piscataway, NJ, (908) 463-5041.

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Project Name: Diabetes Awareness and Prevention Program for the Elderly Hispanic RAZA (DAPPEHR)
Award Year: 1989
Location: San Antonio, TX **Region:** VI
Number: D52 MP 00609
Lead Organization: University of Texas Health Science Center
Type of Organization: University
Target Population: Hispanic Elderly
Target Health Risk Area: Diabetes
Major Intervention(s): Videotape presentations on diabetes education and prevention shown at regional health centers for seven week sessions. Screening for blood pressure and blood glucose provided.
Brief Synopsis: A videotape program for elderly Hispanics about decreasing the risk of complications related to diabetes served as the intervention medium at 90 nutrition sites across Texas. This program proposed to develop a coalition of state-wide organizations involved in services for the elderly, especially for the purpose of teaching poor, older, low-literacy Mexican Americans.
Post Funding Status: The coalition did continue and planned to proceed with health promotion/disease prevention programs. Many good spinoffs occurred as a result of the development of this educational intervention.
Contact: Carolyn Marshall, South Texas Geriatric Educational Center, San Antonio, TX (512) 567-3370.

APPENDIX B

Office of Minority Health
Minority Community Health Coalition Grant Demonstration Program (1986-1989)
Multiple Case Study Analysis

Technical Expert Advisory Committee

Membership

* * *

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Rockville, MD

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Rueben Warren, D.D.S., M.P.H., Dr.P.H.
Associate Director for Minority Health
Centers for Disease Control
Atlanta, GA

APPENDIX C

OMH Minority Community Health Coalition Demonstration Grant
Multiple Case Study Analysis (1986-1989)

TI SITE VISIT TEAMS

1.	**Location:**	***Sacramento, CA:*** Yolo County Ayude Su Corazon Coalition Project
	Team:	Clarence Hall, Charles Cheney
	Field Guide:	Herman Varela
2.	**Location:**	***San Diego, CA:*** San Diego Samoan Community Exercise for Better Health Project
	Team:	Clarence Hall, Charles Cheney
	Field Guide:	Logonh Sotoa
3.	**Location:**	***Washington, DC:*** Community Coalition Project to Reduce Cancer
	Team:	Clarence Hall, Jacqueline Smith
4.	**Location:**	***Fulton and Terrell Counties, GA:*** Black Infant Mortality Project
	Team:	Clarence Hall, Jacqueline Smith
	Field Guide:	William Cammon
5.	**Location:**	***Topeka, KS:*** Kansas Black and Hispanic Coalition on Infant Mortality
	Team:	Clarence Hall, Charles Cheney
	Field Guide:	Mary Hardy
6.	**Location:**	***New Orleans, LA:*** Prevail: An AIDS Prevention Project for Blacks
	Team:	Clarence Hall, Ted Green
	Field Guide:	Cathey Randolph
7.	**Location:**	***Boston, MA:*** Asian Cancer Awareness Project
	Team:	Clarence Hall, Kathleen Quirk
	Field Guide:	Beverly Wing
8.	**Location:**	***Boston, MA:*** Community Coalition to Prevent Black Homicide
	Team:	Clarence Hall, Kathleen Quirk
	Field Guide:	Kathleen Thomas
9.	**Location:**	***Lumberton, NC:*** Accidental Injury Control Minority Health Project
	Team:	Clarence Hall, Jacqueline Smith
10.	**Location:**	***Perth Amboy, NJ:*** Community Partnership for the Prevention of Alcohol and Drug Problems Among Latino Youth
	Team:	Clarence Hall, Charles Cheney
	Field Guide:	Elba Marrero

11.	**Location:**	***Cleveland, OH:*** **Minority Hypertension Detection and Control**
	Team:	**Clarence Hall, Jacqueline Smith**
	Field Guide:	**Muqit Sabur**
12.	**Location:**	***El Paso, TX:*** **The El Paso Coalition for Hispanic Health Promotion**
	Team:	**Clarence Hall, Charles Cheney**
	Field Guide:	**Beatriz Vera**
13.	**Location:**	***Seattle, WA:*** **ACOA Indian Alcohol Prevention Team**
	Team:	**Clarence Hall, Ted Green**

APPENDIX D

OMB Approval #: 0937-0197
Expires: 10/31/93

INTERVIEW INSTRUMENT: PROJECT STAFF/COALITION MEMBERS

Project Title:_____

Date: _____

Interviewee(s) Identification Code:_____

Interviewer(s):_____

Time Began:_____Time Completed:_____

Instructions for interviewer(s) are within brackets ([ ]).

A. PROJECT GOALS AND OBJECTIVES

Extent to which project implementation was consistent with original goals and objectives.

1. What was the **major** purpose of the project?

2. What were the specific services offered to beneficiaries? (e.g. screening, group education sessions, provision of educational materials)

3. In your estimation, how successful was the project? Please explain.

B. PROJECT STAFF AND FUNCTIONS

1. Please explain the roles and functions of the project's key staff.
[DEVELOP STAFF ORGANIZATIONAL CHART]

2. Was there staff turnover during the two-year funding period? Please explain.

3. What was the racial/ethnic composition of the staff?

4. Did the racial/ethnic composition of project staff affect overall project success in reaching the target minority population(s)? Please explain.

5. What was the gender composition of the staff?

6. Did the gender composition of project staff affect overall project success in reaching the target minority population(s)? Please explain.

7. To what extent did the various members of the project staff interact directly with the target population(s)?

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C. FORMATION AND INVOLVEMENT OF COALITION

Factors associated with the formation and involvement of community coalitions in implementing minority health risk reduction projects.

Formation and Composition of Coalition

1. When, for what purpose, and how was the coalition first formed?

2. Did the coalition experience any significant interpersonal tensions among individuals representing its member organizations? Please explain.

3. Did the coalition experience any significant tensions or dilemmas at any point concerning its goal definitions or operational strategy? Please explain.

4. Did the composition of the coalition change during the two-year funding period?

   4.1 If yes, please explain the nature of the change(s).

   4.2 If yes, did the change(s) strengthen __ or weaken __ the project? Please explain.

5. Please characterize the racial/ethnic composition of the coalition board of directors.

Role of Coalition

6. Did the role of the coalition change regarding the project during the funding period? Please explain.

7. Did the respective roles of the coalition's member organizations and representatives change during the funding period?
   Please explain.

8. What was your role in the coalition?

9. Was there a chairperson of the coalition? Yes __ No __

   If yes,

   9.1 How was that person selected?

   9.2 What role did the chairperson play?

   9.3 What effect did the chairperson's leadership have on the functioning of the coalition?

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9.4 Was there a change in chairperson during the grant period?

If there was not a coalition chairperson,

9.5 How were coalition leadership functions carried out?

10. How frequently did the coalition meet during the funding period?

11. What did the coalition do when it met?

12. What was the average attendance at coalition meetings in terms of representation of member organizations?

13. Does documentation exist of the coalition's activities during the project period?

13.1 If so, what is the nature of such documentation (e.g., correspondence, memoranda of agreement, minutes of meetings)?

13.2 Do you have any objection to a review of these documents by the evaluation team? ____Yes ____No.

13.3 If yes, please explain.

14. What types and amounts of resources did the respective coalition member organizations contribute to the project?

15. What types and amounts of benefits did the respective organizations get from the project?

16. How and to what degree did the member organizations interact outside of the coalition?

Effectiveness of Coalition

17. How would you rate the coalition's organizational effectiveness in implementing the project? Would you say the coalition was:

__ highly effective __ moderately effective

__ marginally effective __ ineffective

17.1 What is the basis for this rating?

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18. What special advantages--if any--did the coalition organization and coalition process provide the project?

19. What special disadvantages--if any--did the coalition organization and coalition process provide the project?

Maintenance of Coalition

20. What efforts did the coalition make to secure funding for continuation of the project after the grant period?

21. What other measures were taken by the coalition to maintain its own continuation?

22. Do you feel the local community wanted the coalition to continue to exist? Please explain.

23. Does the coalition still exist? Yes_____ No_____

    23.1 If not, please explain. **[SKIP TO SECTION D]**

24. Has the coalition membership changed? If so, please explain how and why.

25. What are the coalition's current mission, goals and objectives?

26. Which (demonstration grant) project activities have been continued? Have they been changed in any way? Which have been discontinued? Please explain.

27. What new project activities, if any, have been initiated?

28. Does written documentation exist of the coalition's activities beyond the grant period?

    If so,

    28.1 What is the nature of such documentation? (e.g., correspondence, memoranda of agreement, minutes of meetings.)

    28.2 Do you have any objection to a review of these documents by the evaluation team? ____Yes ____No.

    28.3 If yes, please explain.

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D. TARGETED MINORITY POPULATIONS AND HEALTH RISKS

The extent to which the community coalition projects addressed targeted minority populations and health risks.

Target Population(s)

1. What target population(s) did the project initially plan to reach?

2. What proportion of the intended target population(s) was actually reached? Please explain.

   2.1 What data are there to indicate that the project reached all or part of the intended target population(s)?

3. Did the characteristics of the target population(s) change during the funding period? If so, please explain.

4. In retrospect, would it have been best for the project to target a single minority population __ or multiple minority populations? Please explain.

Geographic Target Area(s)

5. What geographic area(s) did the project originally plan to target?

6. During the funding period, did the geographic target area(s) change? If so, please explain.

Targeted Health Risk Factor(s)

7. What health risk factor(s) did the project originally plan to address?

8. During the funding period, were there changes in the health risk factor(s) addressed by the project? If so, please explain.

9. In retrospect, would it have been best for the project to target a single risk factor __ or multiple risk factors __? Please explain.

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E. INTERVENTION METHODS

Intervention methods used by projects to reduce health risks in minority populations.

Specific Intervention Objectives

1. What specific intervention activities or services were originally planned (e.g. screening activities, group education sessions, production of educational materials e.g. posters, brochures)?

2. What percentage of these activities or services were completed during the project period?

3. How were clients selected or recruited for specific intervention activities?

4. What were the major obstacles to those not completed?

   4.1 What was done to overcome them?

5. Do you believe that the intervention activities carried out were consistent with the project's stated goals and objectives? Please explain.

6. Did you produce a comprehensive plan for developing and disseminating health information to the beneficiaries? ____Yes ____No.

7. If yes, may we have a copy? ____Yes ____No

   If no, why not?

Cultural Appropriateness of Intervention(s) for Target Population(s)

8. Were special procedures or approaches adopted (or what did you do differently) to enhance the probability of risk reduction among the target minority population(s)?

   8.1 If something special or different, please explain.

   8.2 If nothing special or different, explain why it was not considered necessary or feasible.

9. Was culture-specific orientation or training provided to the project staff? Please explain.

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10. Did the project develop or adopt intervention or training materials specifically designed for the culture(s) of the target minority population(s)?

    Yes ___ No ___

    10.1 If yes, specify and provide examples of approaches and materials.

    10.2 If not, state rationale for not doing so.

11. Were any efforts made to assess the cultural appropriateness of intervention activities/materials(delete) for the target population(s)?

    Yes ___ No ___

    If yes, was effort:

    11.1 Before major project implementation?

    11.2 What did effort consist of?

    If yes, was effort:

    11.3 After major project implementation was underway?

    11.4 What did effort consist of?

    If not,

    11.5 Why not?

12. Were printed or video materials pretested to ensure cultural appropriateness and determine appropriate language and reading level?

    12.1 If yes, what method(s) were used?

    12.2 If not, why not?

13. How would you rate the appropriateness of the intervention(s) for the target minority population(s). Would you characterize the intervention(s) as:

    __ highly effective __ moderately effective

    __ marginally effective __ ineffective

    13.1 What is the basis for this rating?

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14. What (if any) specific intervention activities were found to be culturally inappropriate for the target population(s)?

F. PROJECT EVALUATION

The extent to which project evaluation, as implemented by the grantees, facilitated implementation of OMH policy, the continuation/expansion of the Community Coalition Minority Health Demonstration Grant Program, and project implementation by the local community coalitions.

1. Did the project fund or implement a baseline study of some sort? Please explain.

2. Did the project implement a post-test, summative or final evaluation of some sort? Please explain.

3. What problems in evaluation, if any, were encountered?

G. PROJECT REPLICABILITY AND GENERALIZABILITY

The extent to which the programs implemented by the demonstration projects could be duplicated in similar communities.
Replicability in Other Communities

1. Would you rate the project's replicability for other communities as highly replicable, moderately replicable, marginally replicable, or not at all replicable?

__ highly replicable __ moderately replicable

__ marginally replicable __ not replicable

1.1 What is the basis for this rating?

2. What components--if any--of the project could not be replicated, or not easily replicated? Please explain.

3. What are the characteristics of the project that enhance the chances of successful replication in other communities?

4. What are the characteristics of the project that reduce the chances of successful replication in other communities?

5. To what extent would you say that the community coalition approach would be applicable to minority populations in other settings? Please explain.

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6. To what extent would you say that the community coalition approach would be useful in reducing health risk factors other than the one(s) addressed by this project? Please explain.

H. OMH GRANT ADMINISTRATION AND TECHNICAL ASSISTANCE

1. Grant Administration

1.1 How would you characterize OMH's overall administration of the Demonstration Grant Program?

a) Excellent b) very good c) average d) poor e) very poor

1.2 How would you describe the overall technical assistance provided by the OMH Washington-based project officers?

a) very helpful b) helpful c) unhelpful d) insufficient

1.3 Was the feedback you received from the quarterly reports submitted to OMH?

a) very helpful b) helpful c) not helpful d) no feedback

1.4 Do you feel OMH understood or was responsive to the problems you may have had during the initial implementation stages of the project?

a) Yes b) No

1.5 Please explain.

1.6 Does OMH priority list of minority health problems from which you chose your intervention(cancer, cardiovascular disease and stroke, chemical dependency, diabetes, homicide/suicide & accidents, infant mortality, and AIDS) cover the priority minority health problems in your community?
a) Yes b) No

1.7 If no, what are the minority health problems (in order of priority) in your community that are missing from the OMH list?

1.8 How do you think the OMH Community Health Coalition Demonstration Grant Program should be structured to be more responsive to local minority community needs?

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1.9 Could OMH have been more helpful during the application, implementation and evaluation phases of the project?

a) Yes b) No

1.10 If yes, please explain.

1.11 Please make any additional comments you wish with regard to the OMH Minority Community Health Coalition Demonstration Grant Program.

2. Did you consider the OMH staff site visits to comprise technical assistance __, monitoring of your progress __, or both __? Please explain.

3. Did the project seek technical assistance from OMH staff?

3.1 If yes, what kind(s)?

3.2 If not, why not?

4. Did OMH technical assistance prove beneficial to the project? Please explain.

5. What technical assistance would you like to have that was not provided? Please explain.

6. Please provide suggestions as to how OMH technical assistance to grantee projects could be improved.

I. BUDGET

1. Was the project budget adequate? If not, please explain.

2. What were the "in-kind" assistance the project received from participating coalition organizations?

3. What were the "in-kind" assistance did the project received from other sources outside the coalition?

J. OTHER COMMENTS AND RECOMMENDATIONS

1. If you were to undertake this project again, what would you do differently?

2. What changes should be made to the OMH grant guidelines to enhance the capability of future grantee projects to achieve the purposes of the Community Coalition Minority Health Demonstration Grant Program? Please provide suggestions.

OMB Approval #: 0937-0197
Expires: 10/31/93

3. What do you think is the legacy or main accomplishments of the project?

4. What were the major unexpected or unanticipated outcomes of this project?

5. What lessons have you learned about coalitions by participating in this OMH Demonstration Grant program?

6. Please make any additional comments or recommendations that you wish.

APPENDIX E

OMH MINORITY COMMUNITY HEALTH COALITION
DEMONSTRATION GRANT PROGRAM MULTIPLE CASE STUDY

ADVISORY COMMITTEE/GRANTEE JOINT MEETING
Stouffer Concourse Hotel
Crystal City, VA
September 23 - 24, 1993

AGENDA

Wednesday, September 22, 1993

All Day Arrivals

Thursday, September 23, 1993

7:30 AM - 8:30 AM	Sign in/Registration	
7:30 AM - 8:30 AM	Continental Breakfast	
8:30 AM - 8:45 AM	Welcome: Joan Jacobs, Program Director, Minority Community Coalition Demonstration Grant Program, Office of Minority Health	
	Anthony Jones, President, Tonya, Inc.	
8:45 AM - 9:15	Meeting Overview	Joan Jacobs
9:15 AM - 10:00 AM	Update and Overview of the Study Discussion	Clarence Hall
10:00 AM - 10:30 AM	B R E A K	
10:30 AM - 11:15 AM	Case Studies Highlights & Discussion	Charles Cheney
11:15 AM - 12:00 PM	Study Generated Hypotheses & Discussion	Edward Green
12:00 PM - 1:00 PM	L U N C H	
1:00 PM - 2:00 PM	Data Results & Discussion	Jacqueline Smith
2:00 PM - 3:00 PM	Lessons Learned, Conclusion, & Recommendations Discussion	Clarence Hall
3:00 PM - 3:30 PM	B R E A K	
3:30 PM - 5:00 PM	General Comments, Questions & Answers Joan Jacobs, Moderator	
6:00 PM - 7:30 PM	Exhibit, Information Exchange and Light Refreshments	

AGENDA

Friday, September 24, 1993

8:30 AM - 9:15 AM	Grantee Racial / Ethnic Work Groups Clarence Hall: Moderator
9:15 AM -10:00 AM	Discussion Reports from Racial / Ethnic Work Groups Joan Jacobs: Moderator
10:00 AM - 10:30 AM	B R E A K
10:30 AM - 11:15 AM	Presentation by Emmanuel Taylor (representing Dr. Rueben Warren), Centers for Disease Control Joan Jacobs: Moderator
11:15 PM - 12:15 PM	OMH: Dissemination/Implementation of Recommendations Panel: Joan Jacobs, Mizzette Fuenzalida, Project Director & Jade Leung, Assistant Project Director, OMH Resource Center Representative Clarence Hall: Moderator
12:15 AM - 12:45 PM	Wrap-up & Adjournment Joan Jacobs

OMH MINORITY COMMUNITY HEALTH COALITION DEMONSTRATION GRANT PROGRAM
MULTIPLE CASE STUDY ANALYSIS FINAL REPORT
Advisory Committee / Grantee Meeting

Stouffer Concourse Hotel, Arlington, VA
September 23 & 24, 1993

CONFERENCE PARTICIPANTS

Present:

Tonya, Inc.
Clarence Hall, Project Director
Kathleen Quirk, Research Assistant
Charles Cheney, Senior Research Associate
Jacqueline Smith, Senior Research Associate

OMH:
Joan Jacobs, Program Director, OMH Minority Community Health Coalition Demonstration Grant Program
Betty Lee Hawks, Associate Director, Division of Information Dissemination, OMH
Mizzette Fuenzalida, Director, OMH Resource Center
Jade Leung, Assistant Director, OMH Resource Center

Advisory Committee
Richard Grzybowski, Milwaukee Indian Health Board
Michael Tristan, Baylor College of Medicine
Emmanuel Taylor for Dr. Rueben Warren, Centers for Disease Control and Prevention

Grantee Representatives

Gerri Alfonso, Pueblo City-County Health Deparment, Pueblo, CO
Elaine Baker, Albany State College, Albany, GA
Margaret Bibum, Deafpride, Inc., Washington, DC
Moon Chen, Ohio State University, Columbus, OH
J.C. Doggett, University of Oklahoma, Tulsa, OK
Penny Emerson, Native Resources, Inc., Window Rock, AZ
Margaret Hargreaves, Meharry Medical College, Nashville, TN
Linda Hudson, Violence Prevention Project, Boston, MA
Linda Jones, Central Seattle Community Health Centers, Seattle WA
Anna Latimer, National Association of Native American Children of Alcoholics, Seattle, WA
Esther Lee, South Cove Community Health Center, Boston, MA
Joyce Lee, High Blood Pressure Council of Greater Cleveland, Cleveland, OH
Sandy Mansonet, University of Medicine and Dentistry of New Jersey, Perth Amboy, NJ
Carolyn Marshall, South Texas Geriatric Educational Center, San Antonio, TX
Debra Oto-Kent, Health Education Council, Sacramento, CA
Margaret Iwanaga-Penrose, Union of Pan Asian Communities, San Diego, CA
Horace Sarabia, Los Barrios Unidos Community Clinic, Dallas, TX
Connie Scott, Robeson County Health Department, Lumberton, NC
Mary Sutherland, Florida State University, Tallahassee, FL
Patricia Theiss, The Bureau of Cancer Control, Washington, DC
Beatriz Vera, Area Health Education Center, El Paso, TX

Participants (con'd):

William Washington, San Jose State University, San Jose, CA
Keith Wells, New Orleans Department of Health, New Orleans, LA
Azzie Young, Kansas Department of Health and Environment, Topeka, KS

Absent:

Edward Green, Senior Research Associate, **Tonya, Inc.**

Ileana Herrell, Health Resources and Services Administration, PHS, **Advisory Committee**
Bernardine Lacey, Howard University School of Nursing, Washington, DC, **Advisory Committee**
Laurin Mayeno Association of Asian/Pacific Community Health Organizations, Oakland, CA, **Advisory Committee**
Aaron Shirley, Jackson-Hinds Comprehensive Health Center, Jackson, MS, **Advisory Committee**

Jon Kerner, Lombardi Cancer Research Center, Washington, DC, **Grantee Representative**
Cynthia Taueg, Wayne County Health Department, Westland, MI, **Grantee Representative**

APPENDIX F

OMH MINORITY COMMUNITY HEALTH COALITION
DEMONSTRATION GRANT PROGRAM MULTIPLE CASE STUDY

ADVISORY COMMITTEE/GRANTEE JOINT MEETING
September 23 - 24, 1993

GROUP REPORTS

This joint meeting marked the last official gathering of the 1986-1989 OMH Minority Community Health Coalition Demonstration Grant Program Grantees and Advisory Committee Members under the OMH Minority Community Health Coalition Demonstration Grant Multiple Case Study OMH/Tonya, Inc. contract. Previous meetings included: Joint Meeting, July 15-16, 1992; Advisory Committee, July 17, 1992; and Advisory Committee, May 10, 1993.

The objectives of the September 1993 meeting were:

1. To review the draft final report and share reflections and insights on the study generated hypotheses, findings, lessons learned, conclusions and recommendations;

2. To review key aspects of the evaluation study and make recommendations for improvements for future studies;

3. To network and share project experiences, informational, educational, and training materials with each other; and

4. Obtain updated information about OMH programs and support services presently available to racial/ethnic minority populations and projects.

The one and a half day meeting was planned by the Tonya, Inc. (TI) Study Team in collaboration with the OMH Project Officer and input from the grantees, advisory committee members, and present & past OMH Project Officers. See Appendix E for the final agenda of the meeting.

Adjustments were made in the original agenda as the situation and interests of the participants changed during the course of the meeting. The TI Team made every effort to model one of the key lessons learned from this study--Flexibility.

The first two sessions of the original agenda for the second day were replaced with a session for work groups and one for work groups reports. A common interest of the cohort groups on day one was the identification of strategies which worked best with the major racial/ethnic populations with regard to coalition building and project implementation. Some of these strategies were touched upon in the case studies but there appeared to be a general interest in exploring this issue indepth during the meeting. At the suggestion of the TI Team Leader, the participants agreed to break into racial/ethnic work groups during the first session of the second day to address this issue.

The representative of the Paso a Paso, El Paso, TX Project suggested a focus for group discussions which was accepted by all participants. African American, Asian, Hispanic, and Native American work groups were formed to discuss what works with regard to coalition building, service delivery, and volunteer involvement in their respective communities.

The following is a summary of Day 1 and Day 2 group reports generated by the participants:

A. Day 1

Cohort Work Groups: Suggestions/Augmentations of the Final Report Conclusions and Recommendations

Grantee Cohort Work Groups
Presentation of Grantee Cohort Recommendations

1986 Cohort:

Recommendations: (OMH)

1. Projects should be funded for five years.

2. Coalitions should enjoy themselves in the process of carrying out their normal functions. Some time should be set aside for socializing and doing fun things together.

3. Identify and document similarities and differences in reaching minority groups that have been learned as a result of the funded studies.

4. Identify the impact which resulted in more time and money for projects funded after 1990. Note the changes from the 1986 cohort to the 1989 cohort.

5. We have not moved to the level of identifying the factors that reduce risk behaviors in minorities:

- *Stronger language should be used in the final report that reflects the cultural structures, historical perspectives, and social analysis and dynamics of each minority group. That is, how social dynamics inform coalition development and community change.*

- *Develop RFAs that move each minority group to the level of reducing risk behaviors.*

Recommendations for Coalition Stabilization: (Projects)

1. Identify basic cultural characteristics and/or potential cultural conflicts of the targeted population - of the ethnic groups with regard to the objectives. There are cultural characteristics and conflicts that must be identified and overcome.

2. Identify "common problem/issue" (motivating force) behind group. For example, in the 1986 ACOA project, people were sick and tired of seeing family members die from the effects of alcohol abuse. This kind of problem affects coalition building and achieving community change.

3. Identify cultural constructs of sub-groups; identify "bridge building" aspects of coalitions. Groups need time to get together to identify and articulate why they are together.

1987 Cohort:

- *While keeping process flexible, OMH should provide: a more general framework; more direction; more feedback.*

Time-saving measures like periodic progress check points, technical assistance and increased interchange with the funding agency will help define expectations, and eliminate time spent on corrections. Evaluation should be ongoing throughout the life of the project.

- *Coalition building vs. loose network building*

As was pointed out, funding agencies promoted turfism and specialization in the past, and now require collaborative work. People may people lack the skills to do this. There may be other forces at work in each community. For example, minorities question the concept of coalition in that the formal structure of the coalition is not how they may actually coalesce - network building may be better. The formal structure of the coalition may be superimposed over the informal networks that are effective in community organizing. Maybe pushing coalitions has not allowed (us) to learn from the informal processes that take place in (our) communities.

- *More work needs to be done in order to systematize cultural knowledge generated by projects to illuminate future interventions. For example, what works in minority communities and why it works. Others could learn from a systematic presentation of these elements.*

1988 Cohort:

Overall recommendations re: Report

- *Identification of Target Audience:*

1) Congress
2) OMH
3) Other practitioners

- *Specificity of conclusions/recommendations*

1) Using objective language
2) Written in measurable terms

- *Executive Summary: with brief background, outcomes, recommendations to be distributed to decision-makers, and cohorts could distribute to local decision-makers.*

Outcomes / Recommendations

I. Coalitions Work

They work to:

- *Mobilize individuals and organizations serving underserved populations.*
- *Engender responsibility; to encourage individuals and communities to take responsibility for their own health.*
- *Give access; underserved communities are not hard to reach, they "have just hardly been reached."*
- *"Grow" resources; expand by working collaboratively.*
- *Advise local, state, and federal decision-makers*
- *Build infrastructure / capacity amongst grass-roots and established organizations to increase their access to communities said hard to reach.*

They work best if they include:

- *Community Participation*
- *Are culturally Appropriate*
- *Include evaluation*
- *Achieve institutionalization (funding, sustainability, infrastructure)*

All can be used as a means to increase buy-in/acceptance of health care reform.

II. Specific Case examples - show numbers, where available, of "success"

III. OMH

- *T.A. / Consultations / Monitoring*
- *Grants Management*
- *Evaluation*
- *Advocacy*

1989 Cohort:

1. *Need for Technical Assistance:*

   - *Provided by someone familiar/ knowledgeable/ have working experience with communities (issues related to culture, language, processes)*

   - *Skills to more effectively negotiate with mainstream institutions for resources (e.g., grantsmanship/funds, printed materials, audiovisual materials, experts, etc.)*

   - *Recognition/respect and funding support reflecting cultural sensitivity (e.g., traditional healing practices, values, attitudes, etc.)*

2. *Increased Access to Services:*

   - *Funding availability to special needs populations such as deaf and other disabled and limited*

English speaking populations (via interpretation services / language, cultural / transportation / limited availability of certified licensed professional - use of teams, training and ongoing learning opportunities for natural helpers).

3. Articulation of similarities across ethnic/special needs populations/communities with respect to effective coalition-building strategies. Examples include issues about utilizing natural helpers, existing social systems, and reinforcement strategies that seem to be effective.

- *Be aware that in program and materials development, there may be geographical and participant parameters, (e.g., diversity of groups, levels of acculturation and ability to absorb into mainstream culture) which may require non-traditional intervention strategies and techniques.*

B. Day 2

Racial/Ethnic Work Groups: Coalition Building, Service Delivery, and Volunteer Involvement: What Works with a Given Racial/Ethnic Group

Racial / Ethnic Work Groups
Presentation of Racial / Ethnic Work Group Findings

Coalitions in Asian/Pacific Islander communities:

Service Delivery:

1. *Avoid tendency to lump together all Asians. Be sensitive to diversity:*
   languages/dialects
   cultures (41+)
   economic levels
   educational levels
   acculturation
   histories

2. *Identify key leadership/gatekeepers (elders, heads of prominent families, religious leaders, natural helpers)*

3. *Importance of interpersonal relations: person-to-person contact paramount (i.e., who is giving the message); persons with established credibility; use of existing social systems, networks*

4. *Least effective channel: government*
   very little credibility, lack of trust, history of abuses/atrocities

5. *Mistrust may be stated as such: "If last meal is bad, you never go back." Cultural norms dictate that politeness be used and one never verbalizes discontent. One bad experience can be enough to tell others not to go. In this kind of atmosphere, project staff must continually reestablish credibility.*

6. *Leaders depend on*
   -problem areas targeted
   -population targeted

-receive sanction from the traditional/political leaders, but work with others who represent other segments of the community.

7. Focus on impact on families, children, or communities rather than the individual needing to change behaviors. Utilize different sets of motivating factors in order to bring about behavioral change.

8. Never promise what you can't deliver

9. Consider traditional healing practices vs. Western ideas of health and prevention. It is important for people to learn about both, so a balance may be achieved with regard to these beliefs.

10. Utilize local networks to organize, i.e., church, temple, homes, etc.

11. Imperative to have bilingual and bicultural staff, not just someone who speaks the language.

Volunteers:

1. No such word

2. First you take care of your families/extended families, then help your immediate community. Why help others outside? (ethnocentric) / family-focused/based. An important factor is the belief in the Asian culture that to have a good country, you need a good family - to have a solid foundation.

3. Focus on what they can gain, e.g., skills, knowledge which will be helpful

Incentives can include: donation to the temples/churches; link to desired people; social/food; "community consultant" stipends; reputation enhancement (where people can be seen as bringing helpful information to the community.)

Coalitions in the African American community:

Global Statement: "One size does not fit all."

1. *Service delivery:*
   a. *There are differences in: gender; geography; cultural orientation; socioeconomic status; and age.*

   b. *Males are effective service deliverers.*

   c. *Traditional healers exist.*

   d. *Engage the church/religious community.*

2. *Non-Traditional Locations for Service Delivery:*

   a. *Barber Shops/Beauty parlors.*

   b. *Social service agencies (welfare/employment offices).*

   c. *Jails.*

   d. *Unions (e.g., bus drivers, public workers).*

3. Strategy: Reaching target population where they are (e.g., in places of employment; homeless/women's shelters; housing developments; health centers.)

4. Types of Service Delivery:

a. Medical (screening, follow-up, etc.)
b. Education
c. Training

5. Volunteer Involvement:

a. assignments should be fun and interesting
b. Compensation ($): "Lay experts" or "community consultants" (formerly categorized as volunteers, people who are experts in the community). These persons should have an equal partnership in the coalition. Compensation demonstrates an effort to recognize the value of their information and their time spent in the community.

c. Recruitment, training, maintenance - should be considered the responsibility of the staff and a staff function.
- Schools/students (e.g., colleges/fraternities)
- Business (e.g., lent out executives)
- AMERICORP (e.g., students who receive federal student loans)
- Churches
d. Recognition is essential
e. Ownership

6. Coalition Development: Guiding Principles

-Diverse and inclusive of all segments of the population, e.g., deaf and disabled. These segments need to be stated, not assumed.

-Include both agencies/providers and consumers in coalition process. Models of inclusion may differ: e.g., consumer coalition / provider consultant board (mixture of both). This represents a sign of equal partners, both of whom bring needed knowledge to the coalition.

Summary:
a. Seek out the population
b. Conduct intervention/education one-on-one
c. Materials development should display basic information (easy reading)
d. Use peer educators

Coalitions in the Mexican American community - which might have similarities to other Hispanic or Latino groups

Coalition-building

• Degree of acculturation (language, traditions, values and beliefs) influences to what degree one is comfortable with the formal structure of the coalition

• Small group discussions are more effective, but require a generating idea for the formation of the group.

• Need involvement/representation of all ages (symbolic of family)

Service Delivery

- *Personal information from participants is difficult because suffering is good, not complaining is standard, and fatalism prevails.*

- *Promotion of services are most effective by word of mouth. People semi-trust radio. People are least likely to trust TV, posters, or flyers. This has to do with the role of government and institutions in the lives of people in the past.*

- *Lack of sensitivity of health care providers to "meanings" of defining health and "compliance." Paternalism is often seen to be used, especially when people feel that too much is being offered to be trusted.*

- *Language is not the problem - communication is a problem.*

Volunteer Involvement

- *Motivation rooted in tradition "help community," church, neighborhood. Not "volunteer" guilt trip (which is a very Anglo concept.)*

- *Don't want to make it a big deal. Recognition has to be subtle, it is just something you do, you "help out," you do not "volunteer."*

- *Issues of needing paid employment. Concur with concept of "community consultant."*

Coalitions in the Native American community:

These themes address community coalition, service delivery, and volunteer involvement from a broader perspective. These are similar guiding principles related to success of a project.

Themes:

1. Honor: for example, in using volunteers, it is necessary to give them respect via verbal acknowledgement.

2. Purpose is for good of group rather than self.

3. Giving and sharing: looking beyond oneself with regard to forming coalitions.

4. Respect: for example, a natural leader must be a person who garners respect, as well as someone who is willing to listen to divergent opinion, and incorporate each contribution into the action taking place.

5. Connectiveness.

6. Circular rather than linear: These two together represent the Native American belief system in that there is a connectedness among all things and people. The circle represents this belief. This is an important concept to emphasize when dealing with problems in this community.

7. Historical experience/knowledge perspective/degrees of acculturation: two examples are 1) in the Navajo language, a hospital is said as "a place where you die," and 2) factors affecting healing and recovery in an ACOA program may come from the underlying pain of the historical experience of genocide. Both relate to the historical relation of oppression of Native American people by U.S. institutions.

8. Humble: re: service delivery - deliver what you promise.